

THE AMERICAN MEDICAL MONTHLY.

DECEMBER, 1861.

ESSAYS, MONOGRAPHS, AND CASES.

Report of Operations performed in the Eye Department of the Brooklyn Medical and Surgical Institute. By Dr. JULIUS HOMBERGER, Ophthalmic Surgeon of the Institute.

(Continued from November No., p. 355.)

31. *Strabismus converg. concom. oc. dextr.* ($4\frac{1}{2}$ lines.) Elizabeth C., 19 years of age, was operated upon both sides for this deformity, on the 26th of August. I saw her a month later, and there was not left the slightest mark by which one could tell that she had ever been cross-eyed.

32. *Staphyloma Partiale. Vascularized Pannus on the external part of the Cornea. Iridectomy.* Annie W. A., æt. 9 years, had on the right eye a prolapsus of the iris, forming a small staphyloma; the cornea was opaque around this, and some small vessels were to be seen upon it. The pupil was not visible; it was drawn outward by the staphyloma, which did not quite occupy the centre, but was a little to the side, and, together with the opacity of the cornea, extended over the third part of the latter. The pannus was the result of a granular condition of the lids. This I had lessened by a treatment of some weeks previously, and when, in spite of the improvement of the lids, the opacity still existed to a certain amount, I practiced iridectomy, hoping thereby favorably to modify the vital processes in

the cornea. The patient could well distinguish day and night before the operation, and saw the flame of a lamp distinctly, even when the flame was not larger than a pea. I performed the operation on the 26th of September, cutting a middling large piece of the iris out, corresponding with the inner, more transparent, part of the cornea. When I saw the patient last she counted fingers and saw my watch, but the beneficial effect of the operation will become fully known only after the inflammatory process in the cornea has entirely subsided.

33. *Strabismus converg. concomit. oc. sin.* (4 lines.) Ellen B., æt. 15 years, was operated upon both eyes at once, on the 4th of September. I saw that her eyes were perfectly straight on the 20th of the same month.

34. *Strabismus converg. concom. oc. sin.* (2½ lines.) One large tenotomy performed upon the eye of Mary B., æt. 15 years; removed the squint of the left eye entirely. I saw her also cured the 20th of September, three weeks after the operation.

35. *Fistula Lachrymalis. Destructio Sacc. Lachrymal.* Mrs. Margaret W., æt. 40 years, came to the clinic with an opening in the skin covering the lachrymal sac, the result of an acute dacryocystitis. The acute inflammation had just subsided. On pressure, some matter was discharged out of the opening, some out of the inferior canaliculum. The patient had suffered from a chronic bleennorrhœa of the lachrymal apparatus for several years. I found, when examining with a probe, an impermeable stricture a little below the place where the abscess had broken. I tried to discover, by an injection of water, whether the nasal opening of the lachrymal sac was closed or not. The patient did not feel any water running down the throat, so I resolved to destroy the whole sac.

In order to effect this, I first introduced a little silver sound, covered with a thin layer of nitrate of silver, in the inferior canaliculum, after I had slit it up just as for Bowman's operation. This has to be done in order to prevent the further absorption of tears, as the cauterization of the canaliculum gives rise to an adhesive inflammation.

The following day I opened the lachrymal sac as usual, and lengthened the cut through the internal lachrymal ligament. The incision I made to pass through the opening of the abscess. After having stopped the bleeding, I introduced a large pointed piece of nitrate of silver, moving it around in the wound, so as to touch every part of the mucous membrane. Having done this, I syringed the sac with some salt water, in order to neutralize the superfluous portion of the caustic.

Cauterizing three or four times, in the same way, I succeeded in obstructing the sac; and the wound was healed, having scarcely left a scar, a fortnight after the operation. In these cases, the running of a few tears over the cheek generally annoys the patient much less than the former lachrymal hernia.

36. *Strabismus converg. concom. oc. sin.* ($2\frac{1}{2}^m$.) James T., ætatis 12 years, was operated upon on the 23d of August. The cellular tissue under the conjunctiva was more extensively divided than usual. The operation effected a perfect cure.

37. *Leucoma Adhærens. Iridectomy.* The patient, Sarah D., æt. 18 years, lost the sight of her left eye by a perforating ulcer on the centre of the cornea. The leucoma is almost round, and has a diameter of two lines; there is nothing to be seen of the pupil, the margin of which is entirely united with the leucoma. The anterior chamber is considerably smaller than usual—almost not existing. I formed a small artificial pupil inward from the opacity, on the 29th September; another one outward some days afterwards. Both the operations were followed by no inflammation whatever, and the patient, who could hardly distinguish day and night before, read with convex glasses middle-sized print (No. XII.) when I saw her last.

38. *Strabismus concom. converg. oc. dextr.* ($4\frac{1}{2}$ lines.) Alfred J., æt. 21 years, was operated upon both sides at once, (20th August.) A squint of half a line was left when he came to see me on the 28th of same month.

39. *Strabismus concom. converg. oc. sin.* (4 lines.) Charles J., æt. 26 years, offered the same deformity as the last patient, on the left eye. The operation, performed on both sides, (21st August,) was perfectly successful.

40. *Cataracta Secundaria.* (Operated per sclerot.) Henry B., a mulatto, 31 years of age, had been wounded on his eye when a child. The pupil was closed by a white membrane, which was the capsule of the lens; resorbed in consequence of the wound. I operated by introducing a needle through the sclerotica, just as in reclinatio; "presenting" the instrument in the pupillar space, and tore the membrane from most of its connections with the posterior surface of the iris. The patient saw rather larger objects a few days afterwards, when I uncovered the eye, but the cataract was still fixed on the iris, and floating often towards the pupil. The patient always noticed this, and said he saw a cloud passing. Though I now propose to repeat the operation, and will certainly succeed in tearing the whole mem-

brane away, I must acknowledge that I feel sorry that I did not remove it by linear extraction.

The patient came to me with a most intense iritis a fortnight after the operation. I had to make paracentesis several times, in order to stop his furious ciliary neuralgia. I did not touch the iris with the instrument, yet induced a more severe iritis than I ever before noticed in consequence of iridectomy or linear extraction.

This case proves how dangerous the operation *per scleram* may become, although considered so safe by some physicians.

Notes on a Case of Poisoning by Strychnia applied to the Puncta Lachrymalia by Langenbeck's Method. By Dr. CHARLES SCHULER

The satisfactory results that M. Langenbeck, of Hanover, has obtained during the last ten years, by his method of inoculating medicinal agents into the subcutaneous tissue, have induced him to make further researches with regard to this mode of treatment. He has recently employed various agents upon the mucous membrane of the eye, especially of the lachrymal organs.

Among these experiments, the application of strychnia to the *puncta lachrymalia* seems to possess considerable interest, from the effects resulting from it.

We cite the following case:

"About six milligrammes of pure strychnia were introduced at different times into the eye of a man 50 years of age, who had long labored under amaurosis of both eyes. The powder was placed at the bottom of the small pocket formed between the lower lid and the eyeball. No effect was produced upon the patient's system. This M. Langenbeck was at first inclined to attribute to the fact that the strychnia, which is not readily soluble, had not been absorbed by the mucous membrane, rather than to any inactivity of the membrane itself, which, as he had often observed, possesses in the highest degree the property of absorbing foreign substances.

He feared that even a very small quantity of one of the salts of strychnia would prove dangerous if placed in contact with the mucous membrane of the eye, these salts being very soluble. He had observed, moreover, that the efficacy of many agents is increased when they have been caused to enter the lachrymal canals; a solution of belladonna, for example, dilates the pupil less rapidly and less per-

fectly when prevented from coming in contact with the lachrymal point. Accordingly, he determined to apply pure strychnia to the inferior lachrymal point. One-twelfth of a grain (less than five milligrammes) was introduced by means of an ear-pick into the left eye upon the point indicated; but as a portion of the powder fell upon the ground, there remained only about three milligrammes. The result was as follows:

"Not more than three or four minutes had elapsed, when the patient's face assumed a livid paleness, and spasmodic yawnings were observed; vertigo then came on, and he fell upon a chair. The windows and door of the room were thrown open; the portion of the powder still adherent to the lachrymal point was wiped off; the patient's face and back were sprinkled with cold water, and enemata were administered.

"In spite of these measures, more serious symptoms of poisoning supervened; at first loss of speech, cessation of the pulse, and laborious and interrupted respiration, followed by violent tetanic convulsions. The spasms were ten or twelve in number; their violence increased up to the fifth, after which they gradually abated. In a short time, though death had seemed inevitable, the patient was somewhat improved; he now felt a painful distention of the bladder and rectum, which was followed by copious evacuations. In less than half an hour he was perfectly restored."

Without attempting to offer a physiological explanation of a fact which proves that a very small quantity of strychnia may speedily cause death when absorbed by the puncta lachrymalia, we would call the attention of our professional brethren to the most important point in this case, viz., its bearing upon medical jurisprudence.

I.—From five to fifteen centigrammes either of pure strychnia, or one of the salts of strychnia, placed in the internal angle of the eye of a sleeping man, would be sufficient to destroy life speedily and silently.

II.—The detection of the poison, which could be found only in the lachrymal canals, and on the mucous membrane of the eye, would be extremely difficult, inasmuch as the powder adherent to the corner of the eye might easily be rubbed off by the hand of the murderer, or of the dying man himself.

III.—Experiments upon vertebrate animals would probably furnish some method of ascertaining the presence of the poison in the lachrymal canals or in the blood. Still it is by no means certain that such experiments would have results similar to those observed in the hu-

man subject, since the lachrymal apparatus of the lower animals is not so immediately dependent upon the brain and spinal marrow as it is in man.

On Pulsatilla. By Dr. JOHN C. PETERS.

Anemone Pulsatilla; Pulsatilla Pratensis; Pulsatilla Nigricantis.
Wind-Flower.

AUTHORITIES: *Sobernheim's Materia Medica; Dierbach's Materia Medica; Vogt's Materia Medica; Frank's Magazine, 4 Vols.; Hamilton's Flora, &c.*

Botany.—It is a small herbaceous plant, indigenous in Northern and Southern Europe, growing in exposed, windy and sunny places, or on arid and barren hills, or in sandy woods. It is recognized by its leafless stems, which are about three to six or eight inches high, with a manifoldly indented sheath under the flowers. It gets its name, *Anemone*, from *anemos*, the wind, because many of the species grow in exposed situations; *Pulsatilla*, from *pulso*, to beat, from its being perpetually agitated by the air; the flower is called *nigricans*, from the dark color of its petals. It belongs to the genus *Anemone*; family, *Ranunculaceæ*; class, *Polyandria Polygna*.

History.—Dioscorides described three varieties of *pulsatilla*, and recommended them principally as external applications to *foul ulcers*, in inflammation of the eyes, and mixed in medicated pessaries for *suppression of the menses*. Pliny recommended all kinds of the plant in *headache*, inflammations thereof, in infirmities of the teeth, and when laid to the *eyes*, as a cataplasm to repress the vehement flux of watery humors thither; also in tertian and quartan agues. But it was on the authority of Baron Störck that this plant was again received into medical use, about the year 1771; while Hahnemann gave a fresh impetus to its use about 1812. It is a singular fact, that the latter exhibited it in very few or no diseases in which it had not been previously used; his extensive acquaintance with the ancient medical authorities led him to use many obsolete remedies in diseases in which they had been given for ages, but not in infinitesimal doses. For instance, Störck advised it as an effectual remedy in many chronic diseases of the eye, especially *amaurosis*, *cataract*, and *opacity* of the cornea; he likewise found it of great use in nodes, nocturnal syphilitic pains, ulcers, caries, indurated glands, herpetic eruptions, melancholy and palsy. The Baron himself had for two years suffered much from the consequences of a violent contusion of the eye, and cured himself with pul-

satilla; two cases of *amaurosis*, three of cataract, and seven differing affections of the cornea, he tells us were either entirely cured or generally benefited by this remedy. Many German physicians have since tried it in diseases of the eye, with more or less success. Among the best known of these, are the celebrated Bergius and Richter, who boldly or wisely increased the dose beyond that recommended by Störck. It was also used by these physicians in menstrual disorders. Of the later *materia-medica* writers, Dierbach classes it among the *acrid diaphoretics*, in company with *dulcamara*, *aconite*, *chelodonium*, &c. Vogt and Sobernheim place it among the *acrid narcotics*, with *conium*, *aconite*, *digitalis*, &c.

Dose.—The plant loses almost all its virtues by drying and steaming; hence large quantities of the tinctures and extracts in common use are almost, if not quite, worthless. Störck's distilled water of *pulsatilla* is very good, and was given in doses of from two to four fluid drachms, from two to four times a day. The powder of the dried plant and the extract were given in from one to three grain doses, several times a day, but are generally valueless. Dierbach directs from five to ten grain doses of the powder of the leaves; or an infusion of the fresh, or carefully dried plant, in the proportion of one-half or a whole drachm to six ounces of hot water, allowed to cool, and taken in divided doses; he says it often happens that very large doses of poor preparations are given without any effect. I can only add, that I have prescribed it for many years, and from some preparations, in large or small doses, could get no effects, either good, bad, or indifferent. This becomes very clear when we are convinced of the well-authenticated facts that the leaves, stem, and root of fresh *pulsatilla* have an acrid, burning taste, and its juice may draw a blister; yet these properties are so much lost by desiccation, that ruminating animals, such as sheep and goats, may eat the *dry* plant with impunity, and without aversion, if mixed with other grasses and herbs.

Effects on the Healthy.—Baron Störck says the following symptoms were usually elicited by efficient doses: pain in the head, wandering and shooting pains, especially in torpid or paralyzed limbs, violent itching of the skin, tormina in the bowels; when the menses were suppressed or scanty, they generally recurred, and became regular in time and quantity; the urine generally flowed somewhat copiously; pains in the eyes were not uncommon, with lachrymation; salivation, lasting some days, has been noticed several times; in cases of paralysis, pains in the legs as far as the groin, and in the back, preventing sleep, have been attributed to it.

Dierbach says if the fresh plant is pounded or bruised, the vapor arising from it is apt to cause itching and pricking in the face and eyes, and this is more especially the case when the extract is making over an open fire. When taken internally in large doses, it often causes profuse perspiration, which may be offensive, and sometimes brings out pustular eruptions on paralyzed limbs; it also often acts as a powerful diuretic; it may cause painful sensations in the salivary glands, and *actual salivation*, somewhat like digitalis has been known to cause. Given in very large doses, it may excite excessive hunger, followed by pains in the stomach, nausea, vomiting, colic, and slimy stools; while suppressed hæmorrhoids and menses are apt to return. Inclination or irritation to cough, frequent sneezing, headache, dimness of sight, vertigo, and trembling have been said to be caused by it. He adds, that it is undoubtedly a very active and useful remedy, which is so often spoiled in the preparation by pharmaceutists that it has often fallen into unmerited neglect.

Vogt writes: "From moderate doses, we observe a more active movement of the fluids and metamorphoses of the tissues, followed by more copious discharges from the internal and external membranes, such as increased flow of urine, greater moisture of the eyes, nostrils, and bronchia, with more or less increase of perspiration. In larger doses it causes increased urination, with more or less of, but not great, irritation about the kidneys, bladder, and urethra; some inclination to cough and sneeze, with increased flow of mucus and expectoration; and more or less perspiration, sometimes followed by the outbreak of small vesicles or other eruptions upon the skin, has been supposed to have been brought about by it in some instances."

Uses in Disease.—Among the disorders in which it has been most frequently and successfully used, may be mentioned various affections of the eyes, such as

Rheumatic Amaurosis.

CASE 1.—A previously healthy and robust person, aged 38, exposed himself, bareheaded, while perspiring, to a very cold draught of air, and was attacked the next day with catarrhal and rheumatic troubles, marked by wandering and rending pains about the eyebrows, which gradually extended to the orbits and teeth, followed by dimness of sight. After being treated for six months with blisters, foot-baths, eye-ointments and washes, vapors of different medicines to the eyes, &c., which had not checked the progress of the amaurosis, he fell under the care of Dr. Helmbrecht. The pupils were natural in size, but the irides immovable; there was much photophobia, with

lachrymation; the rheumatic pains about the eyes, orbits, and bulbs were as severe as ever before, and there was considerable ptosis, with absolute loss of sight. Drastics, diaphoretics, and a seton in the neck were used with but little effect, when finally three grains of extract of pulsatilla were given three times a day, but simultaneously tincture of cantharides, with compound spirits of rosemary, was applied several times a day to the eyelids and brows. There was no improvement in eight, but at the end of fourteen days glimpses of vision were becoming more evident and frequent, and instead of absolute darkness things were seen as through a mist or veil. Then pains in the stomach, canine appetite, followed by nausea and vomiting, commenced to arise; the stools became slimy, the urine copious, and the perspiration very offensive; the patient became debilitated, and a pustular eruption broke out over the body, attended with frequent inclination to sneeze and cough; there were itching in the urethra, headache, with recurrent chills, frequent trembling of the limbs, and especial complaint of peculiar pains about the eyes. These were regarded as effects of pulsatilla, still the doses were increased to four grains each; the diet was improved and strength was regained, while the eruption and gastric affections passed away spontaneously, and the eyesight improved daily. In eight days more the patient could recognize objects pretty well; but at times a mist or fog would seem to arise before the eyes, then fall again, during which he could see nothing. The eyes were more expressive; the irides somewhat movable; the ptosis slight, and all pains in and about the eyes had ceased. The pulsatilla was continued twice a day, and the patient recovered and retained his sight entirely, remaining under observation for some time subsequently.—*Frank's Magazine.*

Erethismus Oculorum.

CASE 2.—A lady who had long been troubled with sensitiveness to, and intolerance of, light, took ten-drop doses of the strong essence of pulsatilla, three times a day, with the best effect.

CASE 3.—Another lady, whose eyes were reddened and excessively painful, was quickly relieved by ten-drop doses, night and morning, of a mixture of ten drops of the strong essence of pulsatilla in half a drachm of alcohol, aided by the occasional external application of the same remedy.—(*Kopp.*)

Scotomia, (False Vertigo.)

CASE 4.—A gentleman, aged thirty-four, had suffered since his sev-

enteenth year, arising from imprudence in diet and conduct, with nervous exhaustion, and weakness both of digestion and sight, attended, from time to time, with false vertigo, vomiting of sour fluid, and violent sick-headache, lasting twenty four hours. He was treated for six years by different eminent physicians, but the affections of the eyes, head, and digestive organs returned at uncertain intervals, and with increasing violence; he also used the mineral waters of Carlsbad, Franzensbrunn, and Cadowa, without relief, and even, in his despair, consulted a notorious magnetizer. Finally, the attacks came on every other day, with such severity and persistence, that slight convulsions often occurred. Then Dr. Lowenhardt treated him for eight months with various metallic oxides, narcotics, &c., with no better results. Finally, the extract of pulsatilla, in two-third-grain doses, was given, every night and morning. In a few days the whole trouble was removed permanently. Dr. L. has met with several other cases in which like favorable results occurred.

(To be continued.)

Case of Poisoning by Acetate of Morphia, in a Child aged seven months.
By S. I. RADCLIFFE, M.D., of Baltimore, Md.

I was called to see the child of G. M. K., seven months old, a large, plump, and healthy male, at 12½ o'clock, p. m., March 5th, 1861, which the mother thought was dying. Upon inquiry, I learned that the aunt of the child had given it a tea-spoonful or more of a mixture which had been prescribed for the father, for coryza or bronchial irritation, under which he was laboring. The aunt, thinking it would answer as well for the children, administered it to two of them, one besides the infant, a boy of some two or three years of age, for what she supposed to be "a cold." The infant was placed on a bed in the room, and about two hours afterwards, the mother, observing that it slept long and soundly, and made a very singular snoring noise, attempted to awaken it, but finding she could not, sent for me. It was not, however, until over three hours had elapsed after the administration of the medicine that I saw it.

Upon examination, I found the infant completely narcotized—in a profound stupor, with stertorous respiration, suffused countenance, contracted pupils, slow, labored, and irregular pulse; it was also completely insensible to all external impressions; the involuntary organs alone acting, and that feebly, to sustain life.

I conceived it at once to be a case of poisoning by opium, or some of its preparations, and dispatched a messenger immediately to the druggist who dispensed the medicine intended for the father, and which the child had taken, for a copy of the prescription; and the following was returned as a correct copy :

R.—Vin. ant.,	3ss.
Acet. morph.,	gr. x.
Spt. nit. dulc.,	3ss.
Syr. scillæ,	3j.
Mel. despumat.,	3iv.

M. Sig. A tea-spoonful *every hour*.

Finding the case very alarming, and would in all probability prove fatal very soon, if something was not done at once, (if anything could be of any service,) I commenced the treatment by trying to induce emesis, but after using syrup of ipecac, until about 2 f. ʒ had been given, and the plentiful administration of mustard, salt, warm water, and other emetics, tickling the fauces, &c., seeing they produced no impression upon the insensible mucous membrane or nerves of the stomach, I abandoned the idea; I directed, then, strong coffee to be given it, its head soused in a basin of cold water, or held over the basin and doused well, repeatedly, and to be kept continually in motion; and sent for Dr. Wm. M. Kemp, their family physician. We discovered deglutition becoming quite difficult, and it was not easy to administer anything by the mouth. We agreed to continue the treatment, and to meet at 3½ o'clock.

3½ o'clock, P. M., about the same—could not arouse it; continued the treatment, with a stimulating injection.

6½ o'clock, P. M., met again—about the same—if any change, seemed more under the influence of the poison; tried it to the breast, but had not the power of suction; it made an effort, seemingly, more from habit than sensibility. Continued the treatment.

10½ o'clock, P. M., called alone, and found the narcotism passing off; opened its eyes for a few moments when spoken to; seemed to recognize persons about it; bowels and stomach emptied, pupils relaxed and enlarging, pulse softer, and more frequent and natural; had nursed freely. Pronounced it out of danger, but directed it to be watched.

6th, 8¾ o'clock, A. M., met Dr. Kemp—symptoms all abated; nurses heartily; decided to leave it without any treatment for the day.

6 o'clock, P. M., a little feverish and fretful, probably from the agitation it received; otherwise doing well.

7th, 1½ o'clock, P. M., met Dr. Kemp. Appears to be entirely relieved. Discharged.

NOTE.—There being 10 grs. of acetate of morphia in the 34 dr. mixture, ($\frac{1}{8}$ gr. being equivalent to about 1 gr. opium,) there was $1\frac{1}{4}$ gr. opium to the dr. or tea-spoonful; consequently the child must have taken about 2 grs. of opium, if it is correct that it took a tea-spoonful and a half of the mixture, which they said was the fact. Comment is unnecessary. The other case was soon relieved by free emesis. No unfavorable symptoms followed either case.

Cretinism and Idiotism. By Dr. F. GUGGENBUEHL, Director of the Hospital on the Abendberg, Switzerland. (Translated and condensed by C. A. HARTMANN, M.D., Cleveland, Ohio.)

The diseases named are, in their different forms and degrees, found everywhere except in elevated situations. Both are branches of one tree, the roots of which spread among the population of whole countries. Wherever cretinism exists, there are also the premonitory indications of it: goitre, stuttering, difficult hearing, weak and cross eyes, disproportionate formation of head and body, defective growth generally. Besides these and other defects of the body, the cretins proper exhibit different degrees of stupidity and idiocy. Cretinism is a disease of the cerebro-spinal system, with defective development of body and mind. Where the body is well developed, the disease is called stupidity or idiocy. In every case, the brain itself is suffering, not the skull only. The sutures of the head ossify sometimes early; the occiput is completely flattened, without offering in that formation anything peculiar to the affection. Disease of the brain is the principal feature; its causes are different. The disposition is congenital. Congestive and inflammatory affections of the brain, softening of the bones, convulsions, acute hydrophthalmus, general weakness, scrofulosis, indicate the presence of the disease during the first year of life. Cretins, however, are not exactly idiots, for some of them show prominent talents and isolated intellectual powers. As weak-minded, and therefore disposed to cretinism, are to be considered all children who cannot be educated and instructed by the usual means and ways. An examination should be made in all such cases, by a physician who has a special knowledge and practical experience of the disease.

For practical purposes, it is sufficient to recognize three forms: 1. The highest degree, called erroneously true cretinism; more prevalent

during the last century than now. Very stupid expression of the face, large head, full nose, thick lips, enlarged tongue, weak, crippled body; want of locomotion, speech, and frequently even of instinct. To this corresponds the highest degree of idiocy: obliteration of the mind, without prominent disease of the body.

2. *Half-Cretins*.—They are able to articulate words, and to be to some degree educated; though usually beggars, they can do mechanical work. Their senses are not very acute, and they like excitement from tobacco, alcohol, fire. Small and emaciated, they have usually large heads. These patients can be considerably improved in their condition. If the body is not implicated, this form amounts merely to dementia.

3. All the bodily effects are present, but not very marked, and the intellectual power is increased to the formation of short sentences. Here, body and mind can be restored to their normal condition by proper treatment. Stupidity is the corresponding affection of the mind. Individuals of this class are frequently very cunning, malicious, and dangerous; the lower faculties develop themselves, while the higher intellectual powers are suppressed. A certain degree of affection is always present, and the cultivation of this, with the general improvement of health, are the keys to a successful treatment. It must, however, be commenced in early life and continued for at least six years. The institution on the Abendberg has, during the eighteen years of its existence, furnished the most astonishing evidence in regard to the efficacy of a proper treatment, although it is not to be denied that the happy results here obtained are, to a certain extent, due to the invigorating influence of the mountain air.

Endemic cretinism always arises from local influences; perhaps from a specific poison. Consequently, the removal of the patients from their place of residence is of the greatest importance. Even in winter the beneficial influence of pure air is manifest, although it is then more irritating, and requires a careful regulation of the temperature in the building. Experience shows that the medical treatment (expressed juices of plants, aromatic baths, cod-liver oil, ethereal solution of phosphorus, etc.) is best limited to the summer-time, leaving the remainder of the year to recreation and instruction. Liability to convulsions forbids, especially, exposure to cold air.

Statistical researches have disclosed the surprising fact that cretinism, in some more or less developed form, prevails in Great Britain and France, to the number of thirty thousand; in Holland, to six thousand, etc. The National Institute at Rhyegate, near London,

the hospital for the exclusive treatment of such patients at the Hague, with several similar institutions in Piedmont and some of the German States, are striking manifestations of the deep interest now felt in the reclamation of these unhappy, and heretofore utterly neglected, beings.

A combination of causes produces the disease, one or the other prevailing in different localities; hence the necessity of further careful and thorough investigations, not in separate localities or single countries, but over whole parts of the globe. Physicians, particularly, must awake to the great importance of such investigations—and some of them have furnished already very valuable contributions. All scientific associations ought to assist in accumulating facts which will enlarge our knowledge of this wide-spread disease, and lead thereby to the establishment of the rules for the most thorough and efficacious educational as well as therapeutical treatment.—*Zeitschr. d. Gesellsch. der Aerzte zu Wien.*

Case of Hydropic Increase of the Liquor Amnii. By JAMES R. WARD, M.D., of Govanstown, Ind.

Mrs. G., the mother of several children, and in good health, was five months *en famille*, when, in the course of two weeks, she found herself rapidly increasing in size, and was so much enlarged that her clothes could no longer be borne unless perfectly loose. She suffered much with dyspnœa, and could rest only when propped up in bed in a half-recumbent position. On my first visiting her, she complained of some pain in the right side, extending down towards the ilium. Her pulse was but little disturbed, her countenance anxious, and somewhat distressed. I ordered an aperient and rest. On the next day I found her in the dining-room. She had passed a bad night, but felt somewhat better. I advised her to keep as quiet as possible, and if the bowels were not moved, to take another aperient. I was sent for early the next morning, and found, upon examination per vaginam, the os dilated and the membranes protruding. I ruptured them, and she soon gave birth to a living five months infant, which cried feebly. The volume of the uterus not being sensibly lessened, I again examined and ruptured another set of membranes, which was followed by a great gush of fluid, and another child, which also cried more strongly than the first. There were two cords and one placenta. The sac containing the first child was entirely separate from that containing the second. The fluid in the first was about the usual quantity; in the second, greatly in ex-

cess, giving rise to the difficulty of respiration. One portion of the amnion was in a normal condition, the other evidently diseased. This is an interesting fact. What gave rise to the increased secretion in the upper sac? What prevented the second sac from being similarly affected?

I have never met with a case similar to the foregoing. In an instance of twins, which occurred in my practice, the first child had been dead for some time, and was entirely separate from the second; the first was born about 9 P. M.; the second at 12 A. M. In this case it was necessary to rupture the membranes, and the mother gave birth to a fine healthy child immediately after the discharge of the amniotic fluid, of which there was a large quantity.

Transactions of the Medical Society of the County of Kings.

JANUARY, 1861.

Dr. BRADY reported the case of a lady previously in good health, not at all nervous in temperament or habits; was confined with first child, and had good delivery; labor not unusually tedious. Seven days after delivery, had a hysterical fit, with symptoms as usual under such circumstances, then fell into a state of torpor, and laid perfectly still; pupils much dilated, yet acting under the influence of light; eyes fixed; pulse 130; sordes on the teeth; will take no nourishment; had been in this condition for three days when the doctor saw her, (in consultation with another physician.) Ordered perfect quietude, the removal of all irritating causes, and gave morphia in full doses. Next day, found the morphia had produced sleep, but she had awoke in the same state as before, and so she continued for four days, making seven days she had been in that condition, when the doctor gave gr. x. of calomel, to be followed in four hours with a large saline cathartic, which produced a large dejection of *black*, offensive matter; repeated the calomel and the saline draught the next day, with the same effect. This was followed with great improvement of the patient, and a speedy recovery.

Dr. NORTH recollected reading of something such a case in the *Buffalo Medical Journal*, reported by a prominent physician of that city, under the head of "Hysterics in a Male." Irritating ingesta were found to be the cause of the peculiar nervous symptoms in that case, and the remedy was a powerful cathartic.

Dr. SMITH related a case of a patient who was attacked with tooth-

ache and neuralgia, pain extending to the whole face. Patient would not bear opiates, and he gave large doses of hyoscyamus, with the effect of relieving the pain; yet, at night, the patient will talk almost incessantly, ask and answer questions as direct and rationally as ever, and in the morning know nothing about it; in fact, she was amused and interested the day following, with a report of her own proceedings during the night—now keeping her comfortable upon the sugar-coated asafœt. pills. Thinks perhaps this state of the patient nights may have been brought on by the pretty free use of chloroform upon the face for toothache, in that way inhaling it for a long time.

Dr. JOHNSON reported the case of a child æt. 6 years having swallowed and passed through the digestive canal a sharp and jagged piece of glass, five-eighths by three-eighths of an inch by measurement, without any unpleasant symptoms whatever. It was retained in the bowels three days. Dr. MARVIN was reminded by this of a little patient of his, who recently passed two large carpet-tacks by stool; and in this case, as in that of the glass, there had been no manifestation of injury.

Chronic Bursitis, or Housemaid's Knee, that had attained an enormous Size. Dr. JOHN G. JOHNSON reported the following case, which he had operated upon with complete success:

The patient was a strong, healthy girl, 25 years of age, who was employed in general housework. Two years ago the bursa was so painful as to compel her to leave her place. She obtained no medical advice, although she states the bursa at that time was as large as a hen's egg. When the patient came under Dr. Johnson's observation, the bursa, as shown by the cast of it, taken at the time, measured as follows: Around the base twelve and a half inches, and when the knee was semi-flexed, the diameter of the bursa was five and one-quarter inches from above downward, and elevated from the patella four and one-fourth inches. The bursa was as large as the foetal head at full term. Dr. Johnson punctured the bursa and evacuated the contents as far as they were fluid, but the bursa soon refilled, and he then adopted the method which is recommended by Mr. Adams, in the *Dublin Hospital Gazette* for May 1st, 1846, namely—opening the bursa freely from above downward—evacuating the contents of the bursal sac, and then exciting inflammatory action by means of a pledget of lint introduced into the cavity. In this operation it was found that the bursal sac was much thickened, containing cartilaginous bodies, attached by a pedicle to the sides of the bursa. These

were removed, and a pledget of lint introduced into the bursa; rest and warm fomentations were employed. Very little inflammation external to the bursa was found to exist the next morning. A new dossil of lint was introduced, and the whole bursa was firmly bandaged, except a small point at the lower part of the opening, which was left open, to allow the bursal fluid and the pus that might be formed to escape. Suppurative inflammation ensued within the cavity of the bursa, which was continued by the introduction of fresh lint every day.

The inflammatory action was limited to the bursa, which was now firmly compressed with straps each day. Two weeks from the time of the operation, the sides of the bursa were completely adherent.

The thickness of the sac had diminished very materially. She now resumed her work, continuing the straps.

The diminution in the size of the bursa has been so marked, that were it not for the cicatrix, it would be difficult to determine upon which knee the bursitis had been.

The liability of the bursa to refill, and the supposed danger of operative interference, have caused various methods of treatment to be adopted. Thus, those surgeons who dread operative interference around the knee-joint, have advised that the cases should be treated in the same manner as a synovitis is treated—by rest, blisters and compression. Another method is, to paint the bursa over with a strong tincture of iodine, and cover the painted part with a piece of lint, to prevent the volatilization of the iodine. This to be continued till the surface was blistered, when poultices were to be applied. A third method has been the introduction of a thread through the bursa and allowing it to remain till slight inflammatory action has supervened, sufficient to cause the absorption of the effused fluid. A fourth method has been the introduction of a seton, and allowing it to remain till suppurative action shall have supervened; then allowing the suppuration to continue till the contents of the bursa shall be changed into pus, and when this abscess shall begin to point, to open it as you would an ordinary abscess, and subsequently, to treat it as you would an abscess. A fifth method has been the introduction of the seton, applying poultices over the bursa, moving the seton to and fro every day, not removing it till the breaking down of the mass was complete. This is recommended by Mr. William Brown, in the fifteenth volume of *Braithwaite's Retrospect*, page 173. A sixth method has been the injection of the tincture of iodine. Seventh, subcutaneous puncture, and the evacuation of the contents of the bursa by this method, has

been recommended so as to prevent the serous cavity from being exposed to the air, and pressure to be subsequently employed.

A still further method has been the introduction of a small instrument, as, for instance, a small trocar or exploring needle, and irritate the sac, and thus produce adhesion of its sides and obliteration of the tumor. Sir Benjamin Brodie has recommended the extirpation of these tumors, in the same manner as an ordinary encysted tumor should be removed. Dr. Johnson preferred, in cases where the contents of the bursa were fluid, or nearly so, to use the method he had in the case reported. By this means, the character of the bursa was changed; it was no longer a bursa secreting an abnormal amount of bursal fluid, but secreted pus; by this means the bursal sac was thinned, and by compression, adhesion took place between the sides of the sac, so that there was no longer a bursa. If we introduced the seton and produced suppuration, allowing the contents of the bursa to be shut up until the abscess should point, it was not impossible that the integrity of the joint might be affected, as pus had a tendency to work in every direction, and the walls of the bursa might become absorbed as rapidly towards the joint as outwards. The removal of the bursa does not insure the fact that it will not be reproduced. Sir Benjamin Brodie details a case in which an enlarged bursa was removed by Mr. Rose, and within two years from the date of the removal it had again formed, and Sir Benjamin himself operated on the same knee in the same manner, excising the diseased bursa.

The plan of operating is not without danger, as, in dissecting the enlarged and thickened bursal sac from the synovial membrane, there is danger of wounding the joint, and all the risks from synovitis, ankylosis, &c., to be met.

The life of the patient may even be a forfeit to this method of operating. Mr. Henry Smith, House-Surgeon to Kings College Hospital, details a case where the patient, a female, of 32 years, died one week after the excision of a bursa over the knee; phlegmonous erysipelas (and perhaps pyæmia) being the cause of death.—*Medical Gazette*, Nov. 6, 1846, p. 785. The introduction of the seton was a valuable method, but Dr. J. preferred to use this only in cases where the contents of these tumors, from continued inflammatory action, had become solid, or nearly so, and as soon as pus was formed in the cavity of the bursa, to open it, so as to allow free exit to the pus, and then to continue with the pledget of lint, and compression. He did not think it safe to confine the pus within the cavity, even in these solid tumors, till they pointed. He had operated upon several other cases

by freely opening them, and inducing suppurative action, and was so well pleased with the results, that he was induced to present them to the Society for their consideration.

One of the cases was in a sea-captain, nearly 70 years of age. In this case of bursitis of the knee, the captain was confined to his bed about three weeks, and the result was completely satisfactory to both patient and surgeon. Prof. Willard Parker saw this patient before the operation, and approved of this method of procedure.

Dr. HUTCHISON mentioned a case in which he had recently operated. The bursa was situated under the annular ligament. He incised the upper portion of the bursa as far as the annular ligament, and attempted to get adhesive inflammation by firm pressure, but he found that the access of air would prevent this. Dr. Hutchison found that it was necessary to change the character of the fluid. He passed a seton through. There is danger of this procedure, by producing too much inflammation. He approved of the method advised by Dr. Johnson. Dr. Hutchison made the opening in the bursa only as large as was necessary to introduce the lint. He had used the tincture of iodine injections, but thought the method suggested by Dr. J. as safe and effectual as any.

FEBRUARY, 1861.

Dr. R. H. HINMAN reported a case, as follows:

A man, aged thirty years, of spare habits and "hang-dog look," waited upon me Tuesday, January 29th, and stated that he had pushed into his rectum a piece of wood, in order to excite an evacuation of the bowels, but unfortunately had forced it up so far that he was unable to withdraw it. After waiting five days, (the bowels not having acted upon his suggestion,) he had come to me for assistance.

At first I did not credit the gentleman's story, but, upon examination, I found his veracity could not be questioned in *that* direction. The stick was *really there*, the presenting end being about four inches within, and deeply bedded in the membrane, lying posteriorly. I endeavored to extract the substance with forceps, but without avail, and after much trouble succeeded in introducing enough of my right hand to grasp and deliver a piece of hard wood, eight inches in length, and more than one inch in diameter.

The only after-treatment I considered necessary was a thorough cleansing of the rectum with warm water and perfect rest, which I found, upon visiting the patient next day, had the desired effect. I

then ordered a large dose of "castor oil," leaving the patient a wiser, and, I trust, a better man.

I will add, that the suspicions which arose in my mind as to the cause for using said piece of wood were confirmed at my second interview, the man acknowledging that he had for some time been in the habit of introducing into his rectum different substances, which would produce a "tickling sensation;" he avowing, however, that he had never before used the *fatal stick*.

The conversation here turned to the kindred subject of "self-pollution," and its degrading and horrifying results, and the experience of the members present as to the best modes of treatment; and in speaking of ergot, Dr. O. H. SMITH said that some few years ago he gave half a tea-spoonful of the strong tincture of ergot every two hours for *delirium tremens*, intending to have used tinct. opii, *but the ergot put the patient asleep*. He was surprised, of course, and supposed it only a coincidence; yet the next case of *delirium tremens* he attended he *intentionally* gave the ergot in the same way and with the same effect, and since he has often used it, and looks upon it almost as a specific for *mania à-potu*, and asks the Society to try it.

Dr. NORTH stated that he had lately seen the following case. A boy, eight years of age, received a severe blow upon the side of the head with an icy snow-ball, which resulted in symptoms as follows:

January 29th, 12 M., was called shortly after the injury; patient in a very irritable, unsettled state; incoherent, frightened, continually moving, and every few moments having convulsive attacks; pulse 130; head hot. Enjoined perfect quiet; feet to be put in hot water and cold applications to head, and half a drachm each of tinct. lupuline and spirits lavend. comp. every hour. Returned at 5, P. M.; found patient in about the same condition, except that the convulsive attacks were more regular and more severe, and of a tetanic character; ordered two leeches to each temple, and to continue the lupuline and lavender every two hours, unless he should sleep, when it should be discontinued; and if the patient should become comatose in the night, to inform me.

January 30th, morning.—Patient apparently not any better; had slept very little through the night; leech-bites had bled freely; convulsions had become very sudden in their attacks, and continued frequent, and the parents were describing how singularly he acted, and how difficult it was to hold him, when he was instantly, from apparent perfect rest and comfort, seized with a tetanic spasm, which appeared as if it would force the breath from his body, and double him

up entirely backward. Without further delay, I gave two grains of calomel and a half grain of opium every two hours. 1, P. M.—No abatement of symptoms; continue treatment. 7, P. M., the same; gave 5 grains of calomel and 10 of rhei.

January 31st, 7 A. M.—Bowels freely opened a short time before; convulsions described as having been very bad during the night, and worse towards morning; gave *verat. viride* and *tinc. camph.*, 1 drop each, every two hours. 1, P. M., easier; patient says he is better; convulsions not so often; continue the medicine, but give every hour, unless he gets quiet and prostrated, when it is to be discontinued. 7, P. M., better; still continue medicine, with same precaution as before.

February 1st, morning.—Better; slept pretty well through the night; has had only two fits; gave medicine only every three hours; 5, P. M., better; no convulsions.

February 2.—Patient has slept well; no convulsions; discontinued medicine; the patient entirely recovered in a few days, without any further return of the tetanic symptoms.

A Case of Catalepsy.—Dr. JOHN G. JOHNSON reported the following case of this somewhat rare disease:

On Saturday, the 27th of April, I was called in haste to see Mr. J., who was supposed to be dying. On my arrival, I found him stretched in an arm-chair, perfectly unconscious, with every muscle tense and rigid. The only history that could be obtained of the case was, that he had that day come to the city from Connecticut, where he had charge of an academy. He complained of a little headache, and of being tired. While sitting, conversing with a friend, he was suddenly seized in this manner. Every muscle was fixed, and hardly movable; the limbs and head were in a straight line with the body. The arms were folded across the chest. There was no movement of the thorax in respiration, and no respiration was perceptible. The pulse was so feeble as hardly to be felt between the rigid tendons. The beating of the heart was very faint. The eyelids were closed, and almost impossible to open; the pupils were contracted, and rolled up in the head. He was completely unconscious; pinching or pricking with pins failed to produce the slightest evidences of susceptibility. The joints were stiff. Mr. J. was raised up by his heels, so that his body was held in a horizontal position, with the neck resting on the back of the chair, and the feet in the hands of an assistant. He was held in this manner, with the most of the weight coming on the back of the neck, till the man was tired of holding him; there was not the slight-

est relaxation of the body, nor the faintest evidence of consciousness; no respiration was perceptible. From the rigid condition of every muscle, the case had the appearance of tetanus, with the exception that the body and extremities formed a straight line, there being neither opisthotonos nor emprosthotonos; and from the lack of consciousness of the patient, we placed him in a number of uncomfortable positions, but he did not manifest the slightest evidence of sensibility. It was almost impossible to move either hand or foot; they retained, however, the position in which they were placed.

The heart's action was so extremely feeble that it did not seem advisable to administer chloroform. The jaws were so firmly clinched that it was impossible for him to swallow the stimulants which were attempted to be given. Mr. J. remained in this rigid, insensible condition for about an hour, when a fluttering of the thorax was noticed. When spoken to, he turned wildly round, with a confused, unconscious stare, and closed his eyes; his limbs became flaccid, and in a few moments he became completely conscious.

In answer to interrogatories, he stated that he felt pain in his abdomen, but nowhere else. Brandy, morphia, and perfect quiet were prescribed. During the night he had a slight return of the cataleptic seizure; this soon passed off, and he continued awake during the whole night, notwithstanding Magendie's solution of morphia was given in twelve m. doses every hour.

Sunday morning, when I saw him, his countenance was quite sallow; he was extremely bilious. He was conscious, and answered the questions rationally, but suddenly, while speaking, was seized again in the same rigid manner as the previous night, and with total loss of consciousness. This attack occurred while Mr. J. was lying on the bed. He was placed in uncomfortable positions, and no indications of consciousness were shown. The limbs would retain whatever position they were forced into. This attack was of short duration, lasting about twenty minutes, when the rigidity of the muscles and joints passed off, but consciousness did not return. He passed into a delirious condition, imagining that some one was attempting to kill a young lady to whom he was engaged, or that an attempt was being made on his own life.

At times, during his delirium, he would figure with amazing rapidity, repeating long rows of figures, and from time to time he would repeat the same figures in precisely the same order. So violent was his insanity, that several men could hardly restrain him. He was perfectly under control, however, when spoken to by a lady whom he

took for the one to whom he was engaged, and would take from her whatever we desired. Hyd. mass. was given, with sulph. quiniæ, and the morphia was continued during the day and night. Tuesday morning the delirium was so violent, and had continued for so long a time without rest, that the patient seemed in a very critical condition, and Dr. Mitchell saw the case, in consultation; in addition to what had been done, the doctor advised the inhalation of chloroform and a turpentine enema. The patient continued in the same violent delirium during the whole of Tuesday. It was found impossible to administer chloroform during the day, as the man became so violent when it was attempted. The hyd. mass. was repeated in the morning, and a strong turpentine enema at night. During Tuesday night he had some little sleep, a few moments at a time. Wednesday morning, availing ourselves of a moment of partial repose, chloroform was administered, and he was kept asleep for several hours. Another turpentine enema was administered while in this unconscious condition, and in the course of a few hours a profuse movement of the bowels occurred. Mr. J. now went to sleep without morphine, and slept for several hours. Quinine and iron were prescribed, with brandy. When he awoke he partook of the brandy and beef-tea of his own accord, and again dropped to sleep.

Thursday morning Mr. J. gave a full and succinct account of his previous condition. Since he graduated from Yale, now nearly — years, he had been employed as a teacher; latterly, having charge of large academies, which had greatly worn upon him; he had taken scarcely any exercise, and his bowels would often go for a week without a movement. In addition to the labors of the day, he devoted himself to mathematical studies during the evening, often sitting till two o'clock in the morning, at work over some difficult problem. It is to this overtasking the mind and the neglect of the laws of health that this condition must probably be ascribed.

One singular feature of the case was, that his hair, which was a jet black, with hardly a gray hair in it, turned nearly gray during the first four days of his sickness, whilst he was in this violent delirious condition. Quinine and iron, with exercise, were directed, and a prolonged absence from his school. Since his return home I have not heard of any return of the seizure.

MARCH, 1861.

Dr. HAWLEY reported a case of *Phlegmasia Dolens* attacking the patient eight days after confinement, affecting both limbs, which yield-

ed very satisfactorily to the prompt use of blisters along the course of the inflamed veins externally, and the administration internally of saline cathartics *only*.

Dr. LEIGHTON reported, in writing, a case, and the results as shown at a post-mortem examination of the same, as follows:

I was called on January the 5th to see Mrs. S., American, aged 18 years. From herself and her nurse I obtained the following history. Five weeks previous to my visit, she was delivered of a healthy child at full term. The labor was natural, but prolonged. On the third day after her confinement, she sprang from her bed quickly, and went to the hall door, which was open. That night she was taken with a violent chill, which was followed by vomiting, severe headache, pain in the back, pain and extreme tenderness over the lower part of the abdomen; suppression of milk and suppression of the lochia. She was bled and purged by the physician then in attendance, and a turpentine stupe applied to the abdomen, which gave temporary relief. Two days after, an offensive discharge from the vagina commenced, which continued for a week, during which time she seemed to be improving.

Some twelve days later, she began to complain of pain in the foot, knee, and hip of the left side, which increased till it became almost intolerable; and from that time she was troubled with irregular chills and sweats. About a week after the pain commenced in the hip, she was attacked with severe pain in the right side of the chest, accompanied with a harassing cough.

Previous to her pregnancy she always enjoyed good health. During pregnancy she had no severe illness, but did not enjoy her usual degree of health. She informed me that her mother died of milk-leg.

When I first saw the patient, she was lying in a half-supine position, but inclined on the right side—the only condition in which she could get any relief from the extreme pain in the left hip and right chest. The skin was pale, and covered with a cold perspiration. The tongue and lips were dry, and the patient very thirsty, continually begging for cold water. The respirations were short, frequent, and difficult; the pulse feeble, frequent, and irregular. She coughed at times, but was unable to expectorate the mucus, which could be heard rattling in the bronchi. On examination of the chest, I found dullness over the whole of the right side, save the infra-clavicular region; and unusual resonance on the left side. Subcrepitant and mucous râles were distinctly heard on the left side, and feebly on the right. The pulsations of the heart were feeble and labored. The left thigh

was greatly swollen; the foot and leg were œdematous. The slightest movement of the leg, or the least pressure over the trochanter major, caused the patient to cry out in agony. There was also considerable tenderness over the lower part of the abdomen.

The treatment was brandy, milk-punch, beef-tea, and egg-nog, to be given as freely as the stomach would tolerate. Citrate of quinine and iron, and sulphuric acid, in mixture, as a tonic; and Dover's powder to allay the pain. The local applications were oil of turpentine to the chest and abdomen, and a fomentation of hops to the hip. On the 7th, Dr. Schapps saw the patient with me, in consultation. He agreed with me in the diagnosis, and an unfavorable prognosis.

The patient was relieved of her extreme suffering, and appeared to improve for several days; but the improvement was soon followed by decline, and after lingering beyond all expectation, she died on the 19th of January, fifty days after her confinement.

I made the post-mortem examination twenty-five hours after death. The uterus was unusually small for one so recently impregnated, being scarcely larger than a virgin uterus. It was of a pale-yellowish color, quiet and soft. The microscope showed the muscular fibres to be filled with fat granules. Portions of the uterine sinuses were obliterated by adhesions. The peritoneum covering the uterus and ovaries was extremely vascular, and had several bands of fibrin, firmly organized, adhering to it. No pus could be discovered with the naked eye in the veins or sinuses; but the microscope revealed an abundance of corpuscles, resembling those of pus in the blood taken from the minute veins. The iliac portion of the small intestines presented increased vascularity. The kidneys were very large and flabby; and the membrane lining them was highly engorged with blood. By gentle pressure, a fluid, resembling milk in color and consistency, was squeezed from the lobules of the kidneys, which, under the microscope, had the appearance of pus. The liver and spleen were hyperæmic. The right lung was compressed into a very small space beneath the clavicle by the pus which filled the remainder of the right pleural cavity. The left hip presented externally the appearance of a dislocation; but the leg was of its natural length, and could be rotated more readily than the healthy one. Fluctuation could be felt posterior to the trochanter major. On cutting through the fascia lata, near the great trochanter, I found not less than a pint of pus, occupying a space between the muscles and superior extremity of the femur.

Further examination showed that the pus communicated with the hip-joint through the capsular ligament and synovial membrane. The

head of the femur was forced from the acetabulum by the pus within the capsule, making the trochanter more prominent than normal, and giving to the hip the appearance of a dislocation. After dividing the capsular ligament, a slight turning of the foot outward threw the head of the bone completely from the socket, and revealed more clearly the condition of the joint. The ligamentum teres was sloughed entirely off. The cartilages of the femur and the acetabulum were destroyed, leaving the greater part of their surfaces bare. The left iliac vein was marked with increased redness, and contained a clot of unorganized fibrin.

Dr. LEIGHTON stated that he had seen a similar case of pleuritic effusion in a patient in Flatbush Hospital, who died a few weeks after confinement, which he supposes might have been a case similar to the one reported.

Dr. SCHAPPS called attention to a case of *Peritonitis*, attended by him, that was pronounced *puerperal* by Prof. Gilman, who saw the patient in consultation, commencing twenty-three days after delivery.

Dr. SCHAPPS also related a case of hysterical blindness and deafness. Patient, an unmarried female; found her with a pulse at 85; no heat of skin yet; great suffering from retention of urine and constipated bowels; drew off the urine with catheter, and administered a cathartic, and relieved the bowels of their vitiated secretion, and the hysterical symptoms were relieved.

Dr. HAWLEY had a patient suffering with albuminuria before and during confinement, who had no convulsions or other serious trouble.

Dr. BRADY reported a case of puerperal convulsions, occurring sixteen hours after confinement with the third child; had convulsions also with first child, but not with the second; he did not see the patient before labor, and could not satisfactorily learn the state of the urine. He bled, and then controlled the convulsions with chloroform; produced evacuation of the bowels in one hour and a quarter, by placing three grs. of calomel on the tongue every twenty minutes. Patient recovered.

MONTHLY SUMMARY OF DOMESTIC MEDICAL LITERATURE.

By T. GAILLARD THOMAS, M.D.

26. *Changes in Woman's Milk produced by Pregnancy and Menstruation. Food most Proper for Infants when deprived of the Mother's Milk.* By N. S. DAVIS. (From Berkshire Medical Journal.)
27. *Case of Double Genu-Varum, or Knock-Knee.* By Dr. LOUIS BAUER. (Philadelphia Medical and Surgical Reporter.)
28. *Causes and Treatment of Dysmenorrhœa and Sterility.* By R. BEVERLY COLE, M.D. (San Francisco Medical Press.)
29. *Anæsthetics in Midwifery.* By B. F. BARKER, M.D. (American Medical Times.)
30. *Case of Rupture of the Bladder treated by Abdominal Section.* By A. G. WALTER, M.D. (Medical and Surgical Reporter. Nov. 16, 1861.)
31. *Experiments upon Inferior Animals to determine in what Manner Chloroform produces Death.* By H. CULBERTSON, M.D. (Cincinnati Lancet and Observer, November, 1861.)
32. *Neuralgia of Fifth Pair.* By Prof. ANDREWS. (Cincinnati Lancet and Observer; from Chicago Medical Examiner.)
33. *An Anomalous Affection—Was it Hydrophobia?* By H. C. PAIST, M.D. (Medical and Surgical Reporter.)
34. *Case of Encephaloid Disease of Kidney—Removal, &c.* By CHARLES L. STODDARD, M.D. (Medical and Surgical Reporter.)
35. *Case of Polypus of the Trachea.* By W. C. B. FIFIELD, M.D. (Boston Medical and Surgical Journal, Nov. 14, 1861.)

26. Prof. N. S. Davis presented to the Illinois State Medical Society, at its tenth Annual Meeting, (1860,) a report on this subject, in continuation of one made to the American Medical Association in 1856.

The present report is based on twelve cases of pregnancy, and eight of menstruation. "In all the cases of pregnancy commencing during the continuance of lactation, there was a noticeable change in the quantity of milk-globules; the full-sized globules being fewer, while the mere granules were increased in number. In the milk obtained while the mother was menstruating, the change was much less observable.

"In eight cases the mothers continued to enjoy as good health as is usual during the first three months of pregnancy, when not complicated with lactation; but their children all began to show signs of insufficient nutrition, coupled with more or less disturbance of the stomach and bowels, before the completion of the second month of pregnancy. In two, the children continued well nourished and healthy, but the mothers both became rapidly anæmic, and the organic nervous system extremely excitable, as indicated by palpitations of the heart, muscu-

lar weakness, and inability to endure even moderate exercise. In the remaining two, both mothers and children continued to enjoy a fair degree of health until the fourth month of pregnancy; but the children drank freely of cow's milk, and sometimes took other nourishment, and the quantity of milk furnished by the mothers was small.

"Of the eight cases of menstruation during lactation, in three both mothers and children continued well; in three others the mothers continued well, but their children were unusually fretful, and subject to frequent turns of slight diarrhœa; in the remaining two the mothers became affected with erythematic inflammation of the mouth, profuse leucorrhœal discharges after each menstrual period, and much general debility, while the children showed no other signs of ill health than unusual peevishness."

From these facts, the inference is, that the child should be weaned when pregnancy or menstruation begins, or supplied with additional food. Which leads Professor Davis to the inquiries, "What proximate and elementary constituents must food contain to render it capable of affording perfect nutrition to the infant? What articles of food contain such constituents? and what state, in relation to fluidity, temperature, &c., is best adapted to the condition of the digestive apparatus in infancy?"

In common with most medical men, Dr. Davis selects cow's milk as furnishing the best substitute for woman's milk. He doubts, however, the existence of any considerable difference in the proportions of the alimentary principles in the two, and thinks the selection of cream much diluted unnecessary and improper.

Woman's milk, on the authority of Simon and West, contains 33 parts of caseine, 24 of butter, and 46 of sugar, in 1,000; cow's milk, 42 of caseine, 28 of butter, and 24 of sugar, in 1,000. A little attention will show that, in order to imitate human milk, we must reduce both the caseine and the butter, but the caseine especially. We therefore take the top of the milk, in which the relative amount of caseine is diminished; and as the two substances are there positively increased, we must dilute it considerably with water.

Dr. Davis found that "fresh human milk gave to litmus a much more decided alkaline reaction than cow's milk; and when allowed to remain in an open vessel, remained entirely fluid, and without any indications of sourness, for a much longer time. Also, that in most instances in which infants were made to depend on cow's milk for nourishment, and they did not thrive well, the failure seemed to be accompanied by a speedy and excessive generation of acid in the digestive

apparatus, indicated either by vomiting of some milk soon after it was taken, or too frequent stools of a curdled appearance and sour smell." He found, by experiment, that cow's milk became sour with coagulation of the caseine in thirty-six hours, while human milk remained perfectly sweet at the end of forty-eight hours. Also, that when diluted, the cow's milk underwent fermentation still earlier. Also, that the addition of lime-water delayed the fermentation, but the addition of a small portion of chloride of sodium or of bicarbonate of soda delayed it still longer. His strong convictions of the evils of much dilution of milk are reiterated at the close of his report:

"From close observation through a series of years, I am satisfied that the excessive dilution of milk, and the use of rice-water, barley-water, bread-water, and such other preparations as require the child to take a large quantity of water to get a small amount of really nutritious matter, greatly favors the prevalence of cholera infantum and diarrhœa, during all the warm season of the year."

27. The patient, a German lad, aged seventeen years, had suffered from congenital knock-knee to a moderate degree; but, since he had embarked in the trade of a baker two years ago, his deformity had so much increased that he could scarcely walk or stand. He applied for relief at the Brooklyn Medical and Surgical Institute. On his admission, he presented the appearance as of great suffering. As the cause of his trouble, a contraction of both biceps and vastus externus muscles was found to exist, and they were consequently divided. By means of four pulleys and proportionate weights, two acting longitudinally and the others transversely, (fastened to the knees themselves,) the deformity was overcome, and when, after four weeks, the patient left the institution, he presented results entirely satisfactory. The improvement has since (four months) been progressive, and the locomotion of the lad perfectly free from any inconvenience.

28. The writer professes to have discovered as a cause of these two evils, a condition of the cervix not described by any author:

This condition consists in double flexion of the cervix, without either anteversion, retroversion, or prolapsion—the os occupying (high up) the centre of axis of the superior strait. In these cases, there is no displacement of the os, but a mere settling down of the body, whereby the long diameter of the uterus is shortened. There is no considerable relaxation of the vagina, and hence but slight of the ligaments; indeed, the difficulty would seem to be due to a want of tonicity in the fibrous structure of the uterus itself, rather than to this condition in either the ligaments or vagina.

On examination with the speculum, there is no difficulty in engaging the os and vaginal portion of the cervix uteri in the instrument; but when the sound is introduced, it is soon arrested, by coming in contact with either the anterior or posterior wall of the canal. It then becomes necessary to elevate, or, perhaps, to depress its handle, in accordance with the direction of the flexure, when it once more advances for a short distance, and is again arrested. It now becomes necessary, generally, to reverse the aspect of the instrument, viz.: if its concavity had been looking forward, to turn it towards the sacrum, or *vice versâ*. In one word, the direction and aspect of the sound is to be changed as occasion requires for its advance, until, finally, it reaches the cavity of the body, when there must be restitution of the instrument effected, or, in other words, it must be turned, so as to cause its concave surface to look forward towards the bladder.

The treatment of these cases consists in the daily or tri-weekly introduction of the bougie, which will be greatly facilitated by first introducing the sound, so as to straighten the canal. Or it may be necessary to resort to the compressed sponge, which, from its longer detention and the stimulation of its presence, will usually overcome such cases as are but slightly benefited by the bougie.

When the bougie is preferred or relied upon, it will be necessary to increase its size, gradually, at each operation, that the pressure necessary to the proper degree of stimulation may be exerted.

29. This is an excellent paper, embodying all that the progressive members of the obstetric profession believe upon this important subject. The author prefers chloroform to ether in obstetric practice, and does not think the statistics of accidents occurring in surgical operations applicable here, for these reasons:

(1st.) The conditions under which they are administered are entirely different. In surgery, the anæsthetic is used to give relief from an *anticipated* suffering. In obstetrics, it is used to destroy pain already existing. There is no law better known in medicine than that the tolerance of narcotics and anodynes bears a certain relation to the intensity of the pain. One suffering from peritonitis or colic can safely and with advantage take a quantity of opium which would be sure to destroy the life of the same individual when in health. For this reason, the risk from such an agent must be very much less in obstetrics than in surgery.

(2d.) The emotional condition of the subject under the two circumstances differs materially: in the one case, tending to weaken nerve-force and depress the vital powers; and in the other, to secure toler-

ance of such an agent by stimulating and supporting the same elements. I do not stop here to discuss more fully the influence of the emotions as affecting the vital functions, although it is a subject of great importance, and one well worthy of the careful study of every practical man. For my present purpose, I think that the mere statement of the proposition is sufficient to secure its acceptance by every mind. When a subject is about to submit to any painful operation and an anæsthetic is proposed, there is always more or less dread and apprehension as to the result, to which is often added an anxiety in regard to the effect of the anæsthetic, whether it will really destroy all consciousness of pain; and if so, whether it will not also destroy life. But in midwifery, the overwhelming desire is to be relieved from the recurrence of the pains; and when the effect of the anæsthetic has once been experienced, it is again sought for with the greatest avidity and confidence.

(3d.) In midwifery, it is ordinarily unnecessary to carry the anæsthetic to the extent to which it is absolutely essential in surgery. In the former, it may frequently be carried to the extent of diminishing or destroying sensation, while consciousness is retained; or, if sleep is induced, it is tranquil, not stertorous. But in surgery it is absolutely requisite that the patient be perfectly still, and the anæsthetic must be carried to the extent of complete sopor, the test of which is heavy snoring. Even if it be necessary to carry it to this extent in obstetrical practice, as it may be in some cases of natural labor, and ordinarily when operative measures, either manual or instrumental, are demanded, the two conditions which have been before mentioned as greatly modifying the danger from the anæsthetic still remain. Furthermore, it may be added, that the system is prepared by the previous use of the agent in a less degree, because there is now no emotional resistance to the effect of the anæsthetic.

His conclusions are these:

In conclusion, I submit the following propositions as a basis for the discussion of the Academy:

(1st.) Anæsthetic aid is of the greatest value in the obstetric art, and chloroform is generally the preferable agent for this purpose.

(2d.) It exerts no injurious effect, when properly administered, either upon the health of the mother or the child.

(3d.) It is perfectly justifiable to use chloroform in natural labor, solely for the purpose of relieving pain.

(4th.) It is especially useful in calming the extreme agitation and mental excitement which labor often produces in very nervous women.

(5th.) It should be administered in those cases of natural labor where the progress is suspended or much retarded by the pain occasioned by previous diseases, or such as may supervene during labor, and in those cases where the irregular and partial contractions occasion intense and almost constant pain, but have no effect to advance the labor.

(6th.) It is of great service in spasmodic contraction and rigidity of the cervix uteri, in tetanic rigidity of the perineum, in certain forms of puerperal convulsions, and in the various obstetrical operations.

30. John Bohland, 22 years of age, blacksmith by trade, of healthy constitution and strong muscular development, was kicked during a fight, on the lower part of the abdomen, on January 12, 1859. Immediately on receipt of the injury, he became weak and faintish, complaining of violent pain in the region of the bladder. Some hours later, being called on to see him, I found the following condition of the patient: The abdomen, without showing any marks of external violence, was somewhat swollen, and exquisitely tender to the touch, more particularly over the pubis, where the injury had been received. His pulse was quick and small, skin cool, respiration short and rapid; incessant were the painful calls at micturition, with inability to discharge urine. There were vomiturations and vomiting; at first the contents of the stomach; afterwards a slimy bilious fluid was ejected.

Some hours later, no mitigation of the painful symptoms being produced, sickness, vomiting, thirst, and distressing calls to urinate, persisting, tenderness and pain increasing all over the abdomen, with tympanitis, and no urine passing by the catheter—there being no remedial agents in our possession for removing the extravasated urine in the abdominal cavity, without which recovery was out of question—the propriety of *opening the abdomen* pressed itself upon our mind, with a hope of success not otherwise to be obtained. In consultation with some medical friends, the novelty of the proposed proceeding, with its probably hazardous consequences, did not find encouragement, and we were left to rest on our own responsibility in choosing a plan of treatment which at least offered a prospect of success, when otherwise the case was sure to end fatally. Advised of the imminent danger of the case, and its certainly destructive tendency, the patient willingly consented to have abdominal section made for the removal of the poisonous urine. Ten hours after the receipt of the injury, assisted by Dr. Guenste, chloroformization having been induced, the abdomen was opened in the linea alba by an incision, beginning one inch below the umbilicus, and terminating about one inch above the pubes,

to the extent of six inches. The intestines were found inflated, their peritoneal coat, as well as that lining the interior of the abdominal walls, already showing evident marks of congestion. A soft sponge was then cautiously introduced into the abdomen, with which the extravasated fluid, consisting of urine and blood, was carefully removed from the pelvis, and between the convolutions of the bowels, amounting to near a pint. While thus inspecting the abdominal cavity, a rent was found in the fundus of the bladder, of two inches in extent, through which the urine had escaped. The cavity of the abdomen being cleansed of the noxious agent, the wound of the bladder was left to itself, as no urine was seen to escape from it. The abdominal wound was closed by strong Carlsbad needles secured by silver wire, (only skin and fascia being stitched, while the peritoneum was left untouched.) A flannel bandage encircled the whole abdomen. The patient, awakening out of the anæsthetic sleep, felt relieved of pain and desire to urinate, so distressing before the operation. Vomiting did not return. Opium again, in one-grain doses every hour, was ordered. Abstinence of drink and perfect quietude of body, with retention of the catheter, were strictly insisted upon. He soon began to doze, had a comfortable night, was free of pain the next morning, complaining only of soreness in the abdomen, without tympanitis, sickness, or calls to urinate; thirst less urgent. The treatment being vigorously continued, for drinks, iced barley-water only in very small quantities, with pieces of ice, being allowed, no unpleasant symptom followed; urine in small quantities, but free of the admixture of blood passing by the catheter. On the third day, the intervals between the doses of opium were lengthened to two hours, on the fifth to three, and thus gradually decreased, as all signs of inflammation had passed, the pulse, though yet quick, having lost its wiry condition. At the expiration of a week, the abdominal wound appeared to be closed by first intention; the stitches, however, were not removed till a week later. The gum-elastic catheter was replaced by a new one every two days, and was not withdrawn for two weeks after the injury had been received, and then only for a short time. At the expiration of two weeks, with the absence of all pain and tenderness, opium was omitted. The intestines were relieved by warm-water injections on the tenth day, when mild nourishment was ordered. Between the second and third week the catheter was permanently withdrawn, and only introduced every four hours, for the evacuation of the urine. After the third week, the patient left his bed, feeling restored to health, and drawing off his

urine himself every four hours. He has remained well ever since, working at his trade and feeling no impediment in his urinary organs.

31. After sixteen experiments upon animals, the author draws these conclusions:

Conclusion 1st: That from the effect of chloroform by inhalation, the lungs will cease to act first and the heart last.

Conclusion 2d: That rapid chloroforming does not always produce congestion of the lungs.

Conclusion 3d: That when congestion of the lungs does result, it is sometimes greater in one than in the other, and often present in one and absent in the other.

Conclusion 4th: That collapsing of the lungs in these cases occurred in every instance inversely as congestion was more or less marked.

Conclusion 5th: That we can offer no satisfactory explanation why chloroform should sometimes produce congestion of the lungs and heart, and again paralysis of these organs; save that it may result from being too profusely or rapidly given. Consequently, to obtain the safest effect of the agent, it should be slowly exhibited, and a large proportional supply of fresh air admitted, that respiration may be unarrested and insensibility gradually induced, by the agent passing through the circulation and reaching the sensorium.

Conclusion 6th: That the chloroform enters the circulation and pursues the natural course of that system, and therefore it cannot travel from the lungs to the right auricle, but must course from the right heart to the lungs after it has passed through the systemic circulation.

Conclusion 7th: If the anæsthetic is applied to the lungs, there is either no congestion of these organs, and much dilatation of the heart, or congested lungs and heart.

Conclusion 8th: It is immaterial whether the paralyzing agent be applied locally to the medulla, or to the lungs. In the latter case, a longer time will be required to kill, provided the case is purely of the paralyzing character, and less if congestion of the lungs result.

Conclusion 9th: That the more potent the paralyzing agent is upon the medulla, the sooner does death ensue, and the less is the heart dilated and lungs congested.

Conclusion 10th: That chloroform may produce a general excitement by being applied to the nervous radicles of the nose, throat and lungs, and also induce local anæsthesia wherever applied. Yet to produce insensibility it must reach the sensorium by circulation, and to cause death by paralysis it must locally impress the medulla oblongata. It matters not how much benumbed the afferent nervous radi-

cle of the endocardium by the local action of the anæsthetic, the medulla will continue to be excited by the blood circulating in it, and thus motor agency be sent down to the heart, until the medulla, too, is paralyzed.

Conclusion 11th: That the chloroform, through the circulation, first impresses the cerebrum, producing unconsciousness; then the sensory ganglia, inducing insensibility; next it acts upon the medulla oblongata and spinal cord; and lastly, it affects the sympathetic nervous system.

Conclusion 12th: That the openings in the heart are not generally obstructed by clots, from the effect of chloroform, and hence death cannot take place from obstruction in this organ. On the contrary, we generally find the blood more fluid than natural, and often excessive in quantity in it. The latter, we have no doubt, may induce death under certain conditions.

Conclusion 13th: The fact that the lungs cease to act first and the heart last, sometimes one being relatively more congested, and again the other, would indicate these organs affected through the same channel, and not the heart solely at fault.

Conclusion 14th: That restoration may take place after the lungs have ceased to act, by the institution of artificial respiration in some form, but not after the heart has ceased to beat.

Conclusion 15th: The excitor nerves of the general surface, the fifth, and of the pneumogastric, are, as is well known, the main afferent nerves of respiration, while the facial, the phrenic, the intercostal and the spinal accessory are the motor nerves. It is evident from this anatomical glance, that there is a large excitor lung surface, but, unfortunately, the nerves of this are paralyzed, consequently exciting agents cannot act here to stimulate the medulla. To a certain extent this is the case with the excitor nerves of the mucous membrane of the upper air-passages. The general surface is unaffected locally, and through the excitor nerves of this must we produce our greatest exciting impression. Thus stimulating frictions, cold and hot douche, the hot iron held near the surface, over the spine from one end to the other, may be resorted to. Galvanism may be tried, applied to the medulla and heart, and through the spine. As to the introduction of agents by the lungs into the circulation, so that they may locally excite the medulla, we fear this is almost impossible, for the heart is palsied, and therefore the column of blood will not be sent on to the brain, even if the restorative advance so far as the heart. It must not be forgotten that the excitor radicles of the left endocar-

dium, too, as well as those of the lungs, are benumbed by the anæsthetic, and therefore, even if the excitant reach the heart, it cannot stimulate it to contraction. It is also plain, too, admitting the excitant could even reach the medulla through the circulation, along with it would flow a *chloroformed blood*, which would add to the local anæsthesia of the medulla, if it did not prevent all influence the restorative might otherwise have had.

Again, the heart is mostly supplied from the sympathetic—consequently, could the restorative pass to the medulla, but little effect would reach the heart through the few cardiac motor branches of the pneumogastric. From such considerations as these, it would seem that restoration is probably impossible after the heart has ceased to beat.

It may be that in our experiments we have not properly used the galvanism, and that an exciting fluid could be passed through one of the internal carotids direct to the medulla, and thus stimulate the latter to motiferous action; but this remains to be investigated.

Conclusion 16th: That congestion of the brain, in these cases, seems to be a rare result.

: 2. In a clinical lecture upon facial neuralgia, Prof. E. Andrews gave the following directions in regard to treatment: First remove the constitutional diathesis, (rheumatic, syphilitic, malarious, etc.,) upon which the local constriction depends. If this does not suffice, surgical interference is to be resorted to. Subcutaneous injection of the sulphate of morphine or atropine over the seat of constriction results often in a permanent cure after a few repetitions. The solution must be prepared of such strength that the syringe will hold the required dose of the narcotic, which is the same as when given by the stomach. The proper place of introduction is a spot near the foramen, which is the seat of structure. This spot, being sharply pressed upon by any small hard object, causes an aggravation of the neuralgic pain. Where this method fails, no remedy is left but extirpation of a portion of the nerve. The excised portion must, if possible, exceed half an inch in length, and is to be taken from the proximal side of the constricting foramen. If the mental foramen of the inferior maxilla be the offending spot, operate at the angle of the jaw, by dissecting up the soft tissues, applying a large trephine upward and forward from the angle, cutting through the external table, prying out the button with an elevator, and dissecting the nerve out. If the fault is at the infra-orbital foramen, a flap must be raised from the cheek as high as the edge of the orbit, and a trephine applied to the front of the antrum Highmori. The button of bone being removed, the bony

ridge concealing the nerve is broken down with some suitable instrument, and the nerve itself dissected out. For excision of the supra-orbital nerve no operation upon the bone is necessary.

33. On the 4th of October, 1861, the author was called to see a cook, æt. 44 years. His pulse was about 90, weak and somewhat intermittent, extremities cold; in fact, the whole surface of his body was below the standard temperature. He also complained of the itching and tingling mentioned by his brother; the least touch on his person by another would throw him into the most violent jactitations from head to foot, with dreadful choking, and earnest appeals, "Don't, oh! don't touch me." I noticed a wash-bowl near his bed, containing about a half pint of saliva; I directed his attention to it, and asked him if that was *water*; the mention of water convulsed him to a dreadful degree, and he cried out, "Don't! don't!!" Not wishing to fill those present with alarming apprehensions, I endeavored to calm him by dropping the subject. I ordered him pills of morphia and asafœtida, and after giving some other directions, left him, promising to return in the afternoon. On my second visit, I found all the symptoms aggravated. I no longer kept my suspicions to myself, but let the family know them, and requested of the brother the privilege of bringing in another physician. I called in Dr. H. Rihl, and we made a number of experiments, such as offering him water, pouring water from one vessel into another, took a lighted candle before him, directed his attention to a looking-glass which was in the room, fanned him in the face, and again behind him when he was not aware that any one was about to fan him, slipped around behind him and touched him, struck the floor with a cane, and many other trivial experiments, all with the same result, followed by the most violent and shocking contortions of the whole body, choking and copious expectoration of saliva. We asked him if he suffered pain in any way; his answer was, "No;" we then asked if he had been bitten recently by a dog or any other animal; his answer was, that 18 or 20 years ago a watchman's dog near Coates and Front Streets had bitten him, but the condition of the dog he did not know, nor never heard afterwards. He had not taken many of the pills—could not swallow them; we tried to get him to swallow one, but without success; the very thoughts of swallowing appeared to convulse him. At this visit, we directed a blister along the whole extent of the spine, to be followed by a dressing of morphia. Called again at 10 P. M.: found our patient worse in every respect; mind wandering slightly, pulse weaker and more frequent, extremities cold, general distress increased, convulsive jerking much more fre-

quent, spitting large quantities of saliva all around him on the bed or on the floor, or anywhere; this we noticed particularly from the fact of his observing much care on our previous visits where he spat. We endeavored to give him chloroform by inhalation, but with ill-effect. He seemed to have an idea that we were trying to smother him to death; indeed, he seemed apprehensive of danger from every one around him; however, by much perseverance, we succeeded in getting him to inhale enough to slightly quiet him. We directed his brother how to use the chloroform, and left him, promising to make an early call the next morning, and on calling were informed that he had died about 4½ A. M. Were told that chloroform was kept almost constantly to his nose, but without much effect; he died in a sane state of mind, the symptoms continuing till death.

34. On the 4th of June last, I was invited to assist Dr. E. D. Wolcott, of Milwankie, in the removal of a tumor from the abdomen of Mr. J., aged 58 years. On examination, we found that the patient was a tall, anæmic-looking man, of a peculiar cast of countenance, indicative of serious organic disease. He stated that he was of healthy parentage, and had good health until the appearance of the tumor six years before that time. The physician in attendance stated, that from the first appearance of the disease, some irritation of the urinary organs had existed, but what the deposits were we were unable to learn, as no reliable chemical or microscopical evidence was presented. It was probable, however, from the statements made, that an albuminous deposit was the principal one.

We found the tumor to be large, filling the right hypochondriac region, and pressing the abdominal parietes forward about two inches from their natural level. On palpation, it was evident that it was semi-solid, having a pedicular attachment, apparently to one of the sulci of the liver, with a more extensive attachment to the posterior parietes.

After the administration of chloroform, Dr. Wolcott proceeded to the removal of the tumor by making an incision diagonally across it down to the peritoneum, which we found to be very much thickened, and slightly attached to it. He next made an incision into the tumor, which we found to be an encephaloid mass. He then proceeded to free it from its extensive posterior attachments, after which he found that the superior attachment was a very dense cord-like structure, about an inch in circumference, and apparently proceeding from the posterior part of the liver. Carefully tying the pedicle, he severed this connection with the knife, and, after removing foreign matter care-

fully from the abdomen, brought the edges of the wound together with common sutures and adhesive strips, which was the only dressing used. After the patient was free from the effects of chloroform, morphia and camphor were administered in sufficient quantities to quiet irritation and produce sleep.

The tumor weighed about two and a half pounds, and on incising it freely, we found undoubted evidence of its being a kidney, from a small portion of its upper portion, which had not degenerated, showing the tubules and a portion of the pelvis of that.

The patient lived fifteen days after the operation, and died, apparently from exhaustion, caused by the great amount of suppuration which necessarily followed.

35. "In March, 1860, she had an attack of asthmatic breathing, with cough and expectoration, which lasted until Aug. 20th. So great was the difficulty of breathing, so large the amount of the expectoration, and so acute the pleuritic stitch accompanying the cough, that I could scarcely doubt the existence of tubercles. The stethoscope, however, showed only great bronchial râles, everywhere present in the chest. During this whole period, from March till August, she never lay down in bed. Propped up with chairs and pillows, she would drop asleep, until her slumber becoming profound, she would fall from the bed to the floor. Getting up, she would again arrange her supports, again perhaps to fall. She was also distressed by the urine being ejected by the violence of the cough: her clothes being always wet, and the urinous odor making her disagreeable to her friends. About the 20th of August, 1860, she had a plentiful eruption of measles. After this, she rapidly grew better, and remained in tolerable health through the winter and spring, the paroxysms being rather mild and rare. The incontinence was less, but still took place when the cough was more than ordinarily severe. She was in tolerably good flesh, but changed from her original tint of rude health to pallor.

About the 1st of July, 1861, she was compelled by poverty to separate herself from her only child. This grief told heavily on her. Shortly after this I saw her. She was then very pale; some dyspnœa; feet and ankles swollen. Auscultation revealed, besides the usual râles, a soft bellows-murmur of the heart, and a well-marked *bruit de diable*, or musical murmur in the neck. Two days afterwards I was called to see her in a fit of hysteria, resulting from an attempt to work, and a conversation regarding her child. Three days after this, she had an attack of dyspnœa, accompanied with vomiting, from which no

relief was obtained. For four days and nights she sat with her forehead resting on the back of a chair—she would allow no pillow or other covering upon it. The weather was intensely hot, and she for the first time expressed an ardent desire for death. It came towards the evening of, I think, the 14th of July.

Autopsy, the day but one following. Body well nourished. Heart healthy. Lungs perfectly free from any tubercular deposit. Right lung pale and crepitant. Left lung of a darker color, moderately congested. No appearance of emphysema in either. The lungs being removed from the body, I divided the trachea to the bifurcation. Cutting into the right bronchus, the floor presented some superficial erosions. The smaller divisions were filled with semi-purulent mucus. Turning my attention to the left bronchus, I could not discover its opening. Looking more closely, I found it perfectly covered by a firm, rosy polypus, the size of a small grape. The pedicle being attached to the trachea, at the mouth of the bronchus, it had acted as a ball-valve, allowing expiration, but forbidding inspiration. No other polypi were seen.

The specimen was transmitted to Dr. Ellis, who has furnished the following description of the microscopical appearances:

"The growth was quite soft, of a whitish color, and appeared to separate into many minute lobules, very loosely coherent. On microscopic examination, however, nothing like lobular structure was seen. It appeared to be composed of small granular corpuscles, each about the size of a pus-corpuscle."

REVIEWS AND BIBLIOGRAPHY.

A Treatise on Diseases of the Joints. By RICHARD BARWELL, F.R.C.S., Assistant Surgeon Charing Cross Hospital, etc. Illustrated by Engravings on Wood. Philadelphia: Blanchard & Lea. 1861. Royal 8vo. Pp. 463.

The progress of surgery during the last ten or twelve years has been very rapid. In some of its departments, indeed, advances have been made so rapidly as to leave behind many of its most distinguished professors. Radical changes have been inaugurated in views and procedures, affecting what had for a long period of time been held as the most firmly established principles. And in the whole range of

surgical science and art, no subject has received greater contributions in positive knowledge and practical devices than that of the volume under review. "A treatise on diseases of the joints, equal to, or rather beyond the current knowledge of the day, has long been required," as truly stated by the author in his preface. Such a treatise is *really needed* by the profession at large, and it but remains to say whether and how, in our opinion, the one before us supplies the deficiency. As to the histology and certain practical points connected with exsection of joints, the name and labors of Richard Barwell are not unknown, and have long been properly appreciated; and though it cannot be said that he has now presented us with the best book that at this day might and ought to be written on joint diseases, we do hold that his undoubtedly is the best book on the subject actually extant.

His four hundred and forty pages of reading matter are divided into eighteen chapters. In the 1st, "Physiological Anatomy of the Joints," he, mainly, but repeats histological views with which our readers are, we presume, more or less acquainted, as they were presented in the MONTHLY soon after they first appeared in the various periodicals. Prominence is of course given to the tubulated character of the articular lamella first described by the author. The wavy channels "running from the deep or osseous to the superficial or cartilaginous surface of the lamella, permit the passage of nutrient fluid from the bone to the deep surface of the cartilage." The whole account of the articular lamella, illustrated by three or four figures, variously magnified, is reprinted from the *British and Foreign Medico-Chirurgical Review*, October, 1859.

With the 2d chapter the subject proper is fairly reached. The whole volume abounds in sound instruction. We have marked a large number of passages deserving the very highest encomiums, while the most diligent search has disclosed to us but few points for criticism, and we sincerely regret that want of space forbids our quoting many of the former, as well as excluding any statement at length of our objections as to the latter. We should especially like to dwell on the notable contributions by Americans entirely unknown, or only partially known to our author. As it is, we must be satisfied with picking out here and there a scrap for either good or evil report, but nothing that we may say must be so construed as to affect the opinion of the book expressed in the last line of our introductory paragraph.

On page 46 we meet with a case of synovitis, the entire production of which is ascribed to gonorrhœa; and on page 91

it is positively stated that the so-called gonorrhœal rheumatism "is but a mild form of purulent infection." The synovitis must certainly have been caused by something besides the mere local disease termed gonorrhœa.

The notion, wide-spread, though undoubtedly erroneous, that the first effect of synovitis is dryness of the membrane, is completely set aside, (p. 51.) "Congestion of the subsynovial tissue, accompanied by rapid secretion of serous or thin synovial fluid into the joint," is properly stated as the first effect of inflammatory irritation.

In discussing the symptoms, the author accurately describes what is of especial practical value—the characteristic position assumed according to the particular joint affected, (pp. 61–64.) This will invariably be found to be that in which least pressure is exerted upon the diseased surfaces. How suggestive this fact is of the grand yet simple principle of mechanical treatment, viz., to keep these surfaces properly apart, is not fully realized by the author. On p. 67 we read, "Of the local means, perfect fixity of the part is the most important;" and on p. 144, "The first and most important part of the local treatment is rest:" both of which sentences, we suppose, were written before he was perfectly familiar with the mechanical treatment of which, following his example, we shall speak a little more fully under the head of hip-joint disease.

Though our author "cordially commends" free incisions into joints to let out pus, he cannot quite divest himself of the bugbear fear of injurious consequences of entrance of air.

The chapter on acute rheumatism is devoted mainly to proving its inflammatory nature, on which point, however, we fully agree with Dr. B.

The symptoms described under the head of Strumous Synovitis correspond to those observed by M. A. Bonnet, of Lyons,* as occurring after long-continued immobility of healthy joints; a coincidence well calculated to weaken our faith in their depending exclusively on the specific cause assigned to them.

Of the chapters on Strumous Articular Osteitis and Hip-Joint Disease, we can say that they, of all others in the book, both please and disappoint us most. We are pleased to find Dr. Barwell follow the right path; we are disappointed to find that he is not fully conscious of the principles on which successful treatment depends; that his appliances are inferior, and that he does not even mention the name of

* *Maladies des Articulations.*

their originator. The attention of the profession at large having been called to the proper mechanical treatment, some six years ago, already, in the editorial columns of the MONTHLY, and numerous communications on the subject having appeared in its pages since, we cannot doubt but that most of its readers are entirely conversant with it; and we had intended, therefore, to dismiss these chapters with the above remark. But as an act of justice to American Surgery, no less than to Dr. Henry G. Davis, of New York, the originator of the treatment under consideration—and in the hope that this notice may meet the eye of the honored author, (for we are confident, from the spirit of honest candor and noble manliness pervading the whole book, that he has not *intentionally* failed “to give honor where honor is due”)—we beg leave to dwell a few moments on the facts of the case. We have for reference only a file of the MONTHLY, and that an incomplete one, at hand, but we think this will prove sufficient for our purpose. We remember that even the pseudo-medical Quarterly, the “*North American Journal of Homœopathy*,” gave the “old school” doctor, as the Humbugpaths delight, in their mildest moods, to call the regular physician, a willing tribute as amply deserving the appellation “public benefactor,” several years ago;* and in a recent discussion before the highest professional tribunal in the Empire City of our State, the NEW YORK ACADEMY OF MEDICINE, the claims of Dr. Davis were fully sustained by the most eminent practitioners. [See *Bulletin*, vol. I., pp. 191 to 224.]

Both the principle on which the treatment is based, and the apparatus by which it is ordinarily most effectually and conveniently carried out, are referred to in the editorial mentioned, which, as far as we know, is the first published account of either. But Dr. Davis had been in the habit of employing the same method in his limited practice for some ten years previously, and whenever occasion offered verbally explained it to his professional friends, and urged its trial upon them. He would enthusiastically dwell upon the revolution which its introduction must work in surgery; upon the benefits it would confer on humanity; the saving of health, of limbs, and life; and would add substantially, that before he published it to the world he wanted to perfect it so that every possible objection should be anticipated and obviated. The then editor of the MONTHLY, Prof. Parker, spoke in the highest terms of Dr. Davis.

The March, May, and June Nos., 1856, of the MONTHLY, contain

* [February, 1857.—ED. MONTHLY.]

a lengthy article by Dr. Davis, on "Deformities and their Remedies;" and here the whole plan of mechanical treatment, not only for *hip disease*, but also for disease of other joints, lateral curvature of the spine, Pott's disease, wry-neck, bow-legs, and club-feet, is fully laid down. Nay; more even, the advantages and applicability of the same principle in the treatment of fractures,* wounds, and all injuries about the joints, are strongly insisted on. The special treatment under consideration was again taken up at the conclusion of "A Case of Pott's Disease, with Remarks on Morbus Coxarius, etc.," MONTHLY, November, 1859; and also in the "*New York Journal of Medicine*," for the same month, (Nov., 1859,) in an article on "The Effects of Pressure upon the Ulcerated Vertebrae, and in Morbus Coxarius, and the Relief afforded by Mechanical Remedies, with Cases." Finally, in April, 1860, he published "*On the Mechanical Means adopted in the Treatment of Morbus Coxarius*. By H. G. Davis, M.D. (*With a Plate.*") From this full and able paper we quote: "I have delayed bringing the subject of this paper before the profession until time had given me an opportunity, not only to overcome any minor difficulties that might arise, but to test its application, and compare the results with the modes heretofore practiced. It is an unfortunate circumstance that so many new things are hurried before the profession in a crude state, to be condemned or die of neglect, when they could have been highly useful if the inventor or discoverer had taken time to digest and mature his plans, and then apply them until all objections or difficulties should be overcome." "Muscular contractions perform an important part in the destruction of a joint," and "elastic extension is the true and philosophical method of overcoming muscular contraction." He tells us he has "invented an apparatus for applying these principles to diseased hip, knee, and other joints," "a method of treating this disease [morbus coxarius] which I have pursued for twelve years; and as it has never been [thoroughly] brought before the profession, it becomes necessary to describe it minutely." Then follows a lengthy description of the instrument, its application, &c., &c. We should also here notice that he has introduced, with the instrument, an important arrangement of material for all surgical purposes, viz., corrugated cast steel, giving strength with lightness.

Thus, surgery is indebted to Dr. Davis not only for the invention

* Dr. Gurdon Buck, of New York City, has fully demonstrated the advantages of the application of the principle to fractures. See *American Medical Times*, and Transactions of the New York Academy of Medicine, Vol. II., Part VII., p. 233.

of an apparatus really yet unimproved upon, but also for the introduction of a method of treatment based on the true pathology of the disease, and the principles upon which successful treatment depends in *all* its stages.

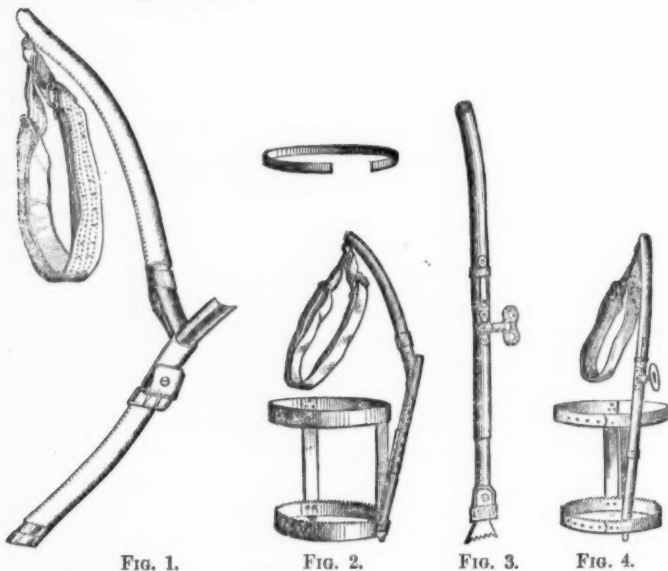
The essential parts of the apparatus are, simply, means of exerting a *continuous-extending force* on one side, and a resisting, counter-extending one on the other. Many persons cannot comprehend in what really consists the difference between Dr. Davis' apparatus and some of the means previously employed, because the word extension misleads them. They do not make the distinction between the force that fixedly sustains a limb in a position previously more or less extended, and the force that is actually extending all the time; *i. e.*, that exerts a constant pulling power, instead of merely preventing immovably the retrocession of pulling previously exerted. Now this continued or "elastic" extension, as, merely to distinguish it, it might be called, has been introduced into the treatment of hip-joint disease by Dr. Davis. Whether it is attained by position, or weights, or spring-power, does not change the principle; but Dr. Davis had brought even his mechanical arrangement to perfection before others entered the field. Indeed, priority here has not been attempted to be proved by any one else, as far as we know. Our author candidly tells us that he had used it in private practice for about a month, when, on the 14th of June, 1860, he was allowed to apply it for the first time in Charing Cross Hospital. Early in the year 1860, for a considerable time before the full description in the April No. of the MONTHLY, Dr. Scudder had, at Dr. Davis' request, as we know from his own lips, taken one of the instruments to England, for the purpose of exhibiting it to the profession there, and in Paris. Adhesive plaster and rubber were used by Dr. Davis from the first. The only quotation we will take the space to make is the following, from the AMERICAN MEDICAL MONTHLY, May, 1856, p. 330: "There is one point in my mode of making extension which I think, from the long experience I have had in its use, would be an improvement upon the general modes—and it is equally applicable in all extensions and counter-extensions, those of fractures as well as of contracted muscles—*viz.*, the use of rubber as an extending power. This will act steadily and gradually, without any violence, and with very little suffering in comparison with permanent fixtures. When contracted muscle is to be overcome, it steadily wearies it, until it silently comes off conqueror. I would earnestly recommend the profession to give their attention to the use of this article for the accomplishment of extension. What is termed a door-

spring is one good form; another, for lighter purposes, is the shirred rubber."

The correspondence of this language with that used by our author (page 326, and bottom of page 267,) is quite remarkable.

The principle of treatment, concisely expressed, consists but in "*ab-traction*" of the joint by *continued-elastic-extension*, securing to the diseased structures support without pressure, and motion without friction. Both of the latter requirements must be satisfied; and though they were equally insisted on by Dr. Davis years ago already, some of the professed improvements on his splint evince the ignorance in this regard (especially as far as refers to motion of the joint) of some prominent members of the profession, even at this day. After Dr. Davis' invention was made, the adaptation of the apparatus to other joints than those he happened to employ it in, hardly entitles a man to any credit; as to the wrist and elbow-joint, we believe ourselves to have been the first to apply the splint.

We should like to have reproduced here the engravings of the "Davis Splint," that we have employed long before any other splint had been brought forward.*



[* Figs. 1 and 2 have previously appeared in the MONTHLY. We are not certain that these are the illustrations our reviewer refers to, circumstances rendering his seeing proof-sheets of this article impracticable.—ED.]

No. 1, an elbow-joint splint. The joint admits of the splint's being shortened during its application. When applied, it is secured straight by a slide. The amount of extension is regulated by the band and buckle at the bottom, or the buckles and cat-gut at top.

No. 2, the same principle applied to the femur.

No. 3, the length is varied by a key and ratchet; the key performing the office of a cog-wheel.

No. 4, the key and ratchet, applied to the thigh portion of No. 2.

Besides the apparatus described by Dr. Barwell, there have been "invented" modifications of Dr. Davis' splint, more or less extensive, and, in our opinion, more or less spoiling rather than improving it, by Drs. Sayre, Andrews, Hamilton, Taylor, E. S. Cooper, Olcott, Veder, etc. In passing, we may here also state, that the "Sayre's Splint," described in the *Edinburgh Medical Journal*, December, 1860, by A. M. Edwards, defeats, by fixating the knee-joint with a cap and strap, one of its first objects.

Considering how much we have with the above remarks overrun the space to which we were limited, we must add, that all we have said we felt bound to say, in the cause of truth and in justice to our whole profession, as well as to Drs. Barwell and Davis. We shall never cease, we trust, to raise our voice, feeble though it may be, to uphold the principle, "*Palmar qui meruit ferat.*"

The two concluding chapters, "On the Restoration of Mobility and Conformity to Crippled Joints," and "On the Removal of Diseased Joints," are unsurpassed in excellence by any previous ones in the book. All that our author says on the subject of excision, comparative statistics of amputation and excision, conditions favorable and unfavorable to excision, methods of operation, etc., we wish every surgeon in the United States would read and digest. We must yet add, that his original "*Casuistique*," embracing sixty-six detailed cases, and illustrations, thirty-two in number, are exceedingly valuable and instructive.

Messrs. Blanchard & Lea, of Philadelphia, deserve the thanks of the American profession for having republished a very useful English work in a very superior style.

D. G.

The Principles and Practice of Obstetrics. By GUNNING S. BEDFORD, A.M., M.D., Professor of Obstetrics, the Diseases of Women and Children, and Clinical Obstetrics, in the University of New York; Author of "Clinical Lectures on the Diseases of Women and Children." Illustrated by four Colored Lithographic Plates and ninety-nine Wood Engravings. New York: Samuel S. & William Wood, 389 Broadway. 1861. 8vo. Pp. 731.

Want of time, alone, prevents us from giving a lengthy critical review of this volume. We do not, however, greatly regret this circumstance, for neither the work nor the profession require much said about it. It seems to have inspired an attachment which nothing but individual possession can satisfy; and if it does not soon overtake the first-born of the Professor's, even, in the number of its editions, it will only be because the issue of each will be manifoldly increased. To praise it, seems somewhat like recounting the virtues of a "sweet-heart" to her lover. Besides, as friendly and more able hands have already rendered ample justice in this particular. Our exchanges vie with each other in expressions of admiration. As to ourselves, we need but refer our readers to the favorable opinion we passed on these lectures when they were first presented to the profession, in the columns of the "*New York Medical Press*," several years ago. The author tells us, indeed, that he has carefully revised and greatly improved the work since then; and this, too, we can emphatically confirm, on comparing the two publications. Especially is this true of the lectures on abortion, post-partum hæmorrhage, and puerperal convulsions. This leads us to add, that the greatest fault we can find with the book, is not that any portion of it is bad, but that some parts are so superlatively excellent, that even the brilliancy of others is obscured.

Hereafter, whether as student or as practitioner, the obstetrician needs no other book, as instructor, guide, or authority, than *Bedford's Principles and Practice*! In typography, paper, and binding, it reflects, also, the taste and elegance of the man.

FISKE FUND PRIZE ESSAY. *The Morbid Effects of the Retention in the Blood of the Elements of the Urinary Secretion.* By WILLIAM WALLACE MORLAND, M.D. Being the Dissertation to which the Fiske Fund Prize was awarded, July 11th, 1860. Philadelphia: Blanchard & Lea. 1861. 8vo. Pp. 80.

As a condensed and generally correct résumé of our present knowledge on one of the most interesting subjects before the profession,

this monograph fully deserves the extensive, aye, world-wide circulation secured to it through the republication by one of the most eminent publishers in America, from the *American Journal of Medical Sciences*, (where it originally appeared, April and July, 1861.) While we regret that Dr. Morland has presented us with but a mere compilation, we must also say that the preparation, at least for its permanent form, of a proper index of its contents, would greatly have aided consultation and reference, and facilitated the student's obtaining an impressive general view of the whole subject.

TRANSLATED FROM THE FRENCH, EXPRESSLY FOR THE MONTHLY.

Lectures on Diphtheria. (Egyptian Disease.) Delivered at L'Hôtel Dieu, Paris. By M. TROUSSEAU.

(Translated by the Editor from La Clinique Médicale de L'Hôtel Dieu, of M. Trousseau.)

(Continued from page 316.)

Tracheotomy.

No one at the present day disputes its Utility and its Necessity—Mode of Operation—The Double Canula—The Dilator—Operate slowly, very slowly—Dangers of the expeditious Method—Dressing of Wound—Canterization of the Wound—The Cravat—General Treatment—The less energetic the previous Medication, the greater are the Chances of Success—Patients must be nourished—Withdrawal of the Canula—A Condition favorable to Success is to operate as early as possible—Unfavorable Conditions—Death is certain when Diphtheria is malignant—It is almost certain in the case of Children under two years of age.

GENTLEMEN—When all the medication we may have employed has failed to prevent the propagation of diphtheria in the air-passages, and croup exists; when we have vainly essayed to combat it by the means which I have pointed out to you, and which, I must say, are the more frequently powerless; or when we may have been called to render our services to a patient only when croup has been for a long time confirmed, asphyxia is imminent, and the patient is doomed to certain death; then, gentlemen, there still remains to us one important resource, namely, *tracheotomy*. Advised by Stoll, (*Aphorismes sur l'Angine Inflammatoire*,) who seems never to have seen it done, this operation was for the first time successfully performed in 1782, by a London surgeon, John Andrée. It was performed upon a child, whose case Jacob Locatelli reported to Borsieri; you will find it set forth in the *Institutes*, (t. IV., *Angina Trachealis*, § CCCCXXXVI.) In the beginning of this century, a French physician, Caron, extolled it anew, although he had performed the operation but once, and then without success. To M. Bretonneau really belongs the glory of the first

success, for the case of John Andrée has been very much disputed. After two unfortunate attempts in 1818 and 1820, the illustrious physician of Tours, in nowise discouraged by these reverses, made a third trial in 1825, upon the daughter of one of his most intimate friends, M. le Comte de Puysegur, who had already lost three children by croup; and this time M. Bretonneau had the good fortune to save his patient. I believe that I am the second who, following the example of my master, performed tracheotomy in cases of laryngeal diphtheria, and the second one, also, to record a cure. The case occurred long ago. The child on whom I operated was the son of a man whose name has latterly had a certain notoriety, Marcelet, the magnetizer of the somnambulist, Alexis. I reported the case in the first number of the *Journal des Connaissances Médico Chiruricales* for the month of September, 1833. At the present day, gentlemen, having performed this operation more than two hundred times, I am so fortunate as to be able to reckon up more than a fourth part as successes. Others after me have entered upon the same pathway, and the results have responded to their efforts. From the Children's Hospital proceeded the impulse which I first gave, and at present there is not a pupil having passed a year in the wards of this establishment who has not cause to felicitate himself for having snatched from the tomb, by means of tracheotomy, one or more children who would have been irrevocably lost but for his intelligent intervention. Having become better instructed by the experience of the past, we attach great importance to the subsequent careful nursing which I shall have occasion to press upon your attention, and the proportion of successes has notably increased. At the hospital of the Rue de Sèvres this proportion has been, for a few years past, more than one-fifth; and this result is considerable, when we remember, on the one hand, the social condition of the children who are brought to the hospital, and the deplorable treatment to which they have been subjected by nurses, quacks, and old women, whose advice is asked rather than that of physicians; when, on the other hand, we recollect especially the attendant dangers of the hospital itself, in which the children operated upon are placed in the very centre of the severest and most varied contagious diseases, so that very often when everything seems to be going on as well as could be wished after tracheotomy, scarlatina, measles, small-pox, whooping-cough supervene, and cause very serious complications. Therefore I do not doubt that in private practice, cure must be the rule in one-half of the cases, provided the operation has been performed under conditions rendering cure possible. These happy results proclaimed on every hand, speak so loudly that all prejudice must fall before them; and I am no longer the only one to advocate the necessity of this operation, and to insist that it is a part of the duty of the physician to perform tracheotomy; a duty as strict as that of performing the ligature of the carotid artery after the wounding of that vessel, although in that case death may follow the operation, certainly as often as a cure. If, in the early days of its introduction, it excited opposition, at the present time it no longer meets with hostility, except among envious, evil-disposed, or ignorant persons.

The opposition which may be presented to it is in nowise serious, and henceforth this triumph of the medical art has taken its place in the domain of ordinary therapeutics.

Tracheotomy consists in opening the tracheal tube in order to give access to the air, whose passage through the natural orifice of the glottis has been almost prevented. The professor of operative surgery will pardon me for trespassing for a moment on his territory, in order to describe to you, if not according to the rules of surgery, at least in my own way, an operation which physicians are oftener called upon to perform than surgeons.

The necessary *instruments* are a slightly convex and sharp-pointed bistoury, and a probe-pointed bistoury, two smooth blunt hooks, with strong handles; in default of them, we may substitute in their place two hair-pins, which can be found everywhere; a *dilator*, a sort of dressing forceps, curved on its flat side, whose two branches form at their extremity a little spur projecting outwardly, so as to cling to the lips of the tracheal wound, and not to become displaced continually during the movements of respiration. This instrument is designed to dilate the opening made into the trachea, in order to permit the introduction of the canula. This *canula* must be double; one, external, the pavilion of which is pierced with two button-holes, to receive the ribbons that are to be tied behind the neck, in order to hold up the apparatus when it is once in place. Independently of these two button-holes, the pavilion has at its upper part a sort of key which plays in a slit made in the corresponding part of the inner canula. This latter having a diameter necessarily less than that of the external canula, is provided at its pavilion with two ears, by which it can be seized whenever we wish to withdraw it or return it to its place; it is fastened to the external canula by means of the little key of which we have just spoken, and which should open and shut easily. The diameter of the canula must be sufficiently great; it will never be too great, provided the instrument enters readily into the tracheal tube. Its curve must be that of a quarter circle; thus M. Mathieu makes them all at the present day, and he has adopted this fixed standard in order to avoid the disadvantages which I pointed out to him; the curve of the different cannulas which had been presented to me, being before either too great or not great enough, because the workmen continually varied from the type of the instrument which had been given to them as a model. The double canula is absolutely necessary; and in truth, when we see in what manner Van Swieten insists upon the necessity of a double tube, and that too in accordance with the authority of the English author, G. Martins, we cannot but ask how it is that this precept has been forgotten, and how it is that, in spite of the recommendation of M. Bretonneau, who from the very outset of his operations used a double canula not curved, we have been able to remain several years without making use of it.

The dilator is indispensable. Once I lost a child during the operation; it was a little patient under the care of my friend, Dr. Barth. I came to the consultation without knowing what was the case in question, and I found the child dying. Dr. Barth had a canula and

a bistoury. I could not put aside the vessels as I would have wished to, because I had no dilator; I groped my way for some time before entering into the trachea, and yet the blood flowed in great quantities into the bronchii and strangled the child, which assuredly would not have happened if I had had a dilator, which would have allowed me to penetrate immediately into the tracheal tube. However, in default of a dilator, we may have recourse, in order to introduce the canula, to the process devised by Dr. Paul Guersant. It consists in arming this canula with a mandrin, a simple sound of gum-elastic, which passes several centimetres beyond the lower opening of the tube. You will readily perceive how much this modification will simplify the manual operation. The sound is easily introduced into the tracheal wound on the finger, which serves as its conductor, and it answers every purpose to slip the canula upon it in order to put it in its place.

Now let us proceed to the consideration of the operation. The patient is lying on a table furnished with a rather thin mattress, and with a coverlet several times folded; a pillow rolled up, or better still, a roll of cloth should be placed under the shoulders and the posterior portion of the neck, in such a manner as to stretch the anterior region, and to bring as much as possible into relief the trachea, which we propose to look for. This position is without doubt terribly uncomfortable, especially for a person already suffocating, but it will not have to be maintained a very long time. An assistant placed behind the patient will be charged with the duty of holding his head firmly; another assistant, placed in front of the operator, will be charged with the duty of removing the different layers of tissues and sanguineous vessels with a blunt hook, which he will hold in his left hand, while with the right hand he will be ready to sponge the wound with the fine sponges which should be arranged by his side. Other persons will be needed to prevent the patient from moving. Finally, to omit nothing, if you operate at night, some one will have to hold the candle, which should give a bright light. If the operation is performed by daylight, the patient must be placed directly in front of the window of the room, with his feet towards it, so that the light may fall full upon his neck.

These precautions being taken, the physician standing at the right of the patient—I say at the right, and not on the left, because otherwise he will be annoyed by the projecting chin, unless, indeed, he is ambidexter—the physician standing, then, on the right of the patient, will seize the tracheal region with his left hand, while with the right he will make along the mesian line an incision extending from the cricoid cartilage as far as a little above the sternum. The importance of cutting along the mesian line is such, that by reason of not having made the incision following this exact direction, we may be greatly embarrassed throughout the whole subsequent operation; therefore I recommend to those of you who have no surgical pretensions, to define beforehand the course of the bistoury by a mark made with ink or with a burnt cork. The incision passes successively through the skin and the cervical aponeurosis, and we then come to a small white line which marks the separation of the muscular masses. We sponge

away the blood, which is already flowing fast; we then cut along this little white line and separate the sterno-hyoidian and sterno-thyroidian muscles, which, with the blunt hook held in the left hand, we detach from one side, at the same time that the assistant in front of the operator separates them from the other. Here begins the difficulty.

We now come to the isthmus of the thyroid gland, whose size and position, as you know, vary to such a degree that sometimes it only covers the first ring or the uppermost rings of the trachea, while sometimes it has the same height as the body itself. Lower down we find the thyroidian venous plexus, and the artery of Neubauer, when it exists. Then the physician must not forget this capital precept, namely, to respect the vessels. If he sees a large vein he should dissect it, and hold it by drawing it out with the blunt hook. If the left subclavular vein, swollen with blood, projects into the jugular cavity, we must depress it and protect it with the finger, for a terrible accident, I need not say, would be the consequence of wounding it; for a still stronger reason must we pay attention to the brachio-cephalic trunk, which, in the case of children, sometimes projects considerably beyond the supersternal fork.

When we come to the trachea we must free it from all obstacles, and then puncture it by making a small incision as near as possible to the cricoid cartilage, and by directing the bistoury along the nail of the index finger placed at the bottom of the wound. A hissing sound indicates that the trachea is open; we use the sponge, and through the opening made we introduce a probe-pointed bistoury to enlarge the incision. If this incision is made far from the cricoid cartilage, we must enlarge it from below upward in order to avoid the brachio-cephalic trunk. Many practitioners prefer to open the crico-thyroidian space, and to cut the cricoid cartilage and the first two rings of the trachea. A moment's reflection will suffice to make it apparent that in acting thus we must necessarily penetrate into the larynx itself, and that if, as quite often happens, the canula remains several weeks in the wound, a partial necrosis of the cricoid cartilage, and even of the thyroid cartilage, will be produced, which may become the source of the gravest ulterior accidents, besides that an irremediable alteration of the voice may result from it. I speak, it must be understood, of what must be done in the case of croup in young persons and in adults, for when I shall speak to you of tracheotomy in other affections of the larynx, I shall tell you that in that case, when treating aged persons, we are sometimes obliged to act otherwise. In the case which occupies our attention it is merely necessary to open the tracheal tube.

I cannot too earnestly insist, gentlemen, upon the necessity of cutting through the tissues, layer after layer, of removing the vessels and muscles with the blunt hooks, and of stripping the trachea completely before opening it; I insist upon the absolute necessity of operating *very slowly*. If even during the operation the child is strangled, stop, let him recover himself, and let him sit up in order to get his breath; there will be a minute lost, perhaps, but there is nothing to fear. I have never seen *too great slowness* the cause of an accident,

and I have often been the witness of the difficulties and dangers of tracheotomy when *too quickly* performed, even when it was done by a skillful operator.

I therefore oppose with all my power the *expeditious* method recommended latterly by Dr. Chassaignac, and which consists in rendering the larynx motionless by means of a tenaculum, in order to penetrate directly into the trachea by cutting through the skin and the parts beneath with one and the same puncture. This process is moreover far from being new. In 1586, Sanctorius, who seems first to have performed tracheotomy, laid down the principle of puncturing the trachea with the trocar which he had invented for abdominal paracentesis.

In 1748 Garengot also recommended *laryngocentesis* as much superior to the operation by which we reach the trachea by passing through successive layers; still Garengot* prescribes incision of the skin beforehand, without disturbing the muscles, at least in the case of thin persons. This method, the direct puncture without previous incision, is also advised by Heister,† because it is more expeditious, and because the canula being introduced at the same time with the trocar, the patient is spared new sufferings. Decker, Bauchot, Barbeau, Dubourg, Richter, had devised *bronchotomes* in order to render the operation more simple and more expeditious still. Van Swieten, in his commentary 813, in which he has treated of bronchotomy at length, opposed this method, whose dangers he readily perceived, having tried it upon the cadaver and upon living animals.‡ A. Bérard, who had himself also devised a process analogous to that of Heister, learned that the quickest method was not always the best, and towards the end of his life he gave it up, to return to the more common and the more certain process. Dr. Paul Guersant likewise adopted for a time, the expeditious method; but at the present day, although he operates more quickly and better than those among us who are not surgeons, he proceeds very slowly, in order to avoid the serious difficulties which I have pointed out. On the one hand, there is danger in holding the larynx; for, as Dr. Millard has judiciously observed in his excellent thesis,§ as Dr. Lenoir also said in 1841, (Thesis on Bronchotomy,) by opposing movements which are connected with the exercise of a function already seriously threatened, you run the risk of hastening asphyxia and death; on the other hand, you run the risk of exciting mortal hæmorrhages, if by any chance your instrument should meet with arterial anomalies, as in a case communicated to me by Dr. Richet. While operating upon a little girl who was suffering from croup, he was obliged, at the very moment he was about to open the trachea,

* Opérations de Chirurgie, t. II., p. 447 et 448.

† Institutions de Chirurgie, t. III., p. 153, année 1770.

‡ "Tentavi aliquoties in cadavere et in viris animalibus hanc methodum, sed videbatur mihi admodum difficilis, et non carere periculo, ne quandoque valida vi adactum instrumentum deviare, unde crederem priorem methodum, licet magis operosam, preferendum esse."—(G. Van Swieten, *Comment. in Herm Boerhavi Aphorism, de Cognoscere, et Curare Morbis*, Aph. 813, t. II., p. 627.)

§ De la Trachéotomie dans le Cas de Croup, Paris, 1858.

to cut an artery almost as large as the radial; there was anastomosis of the two inferior thyroids. A ligature applied to the two extremities of the divided vessel stopped the hæmorrhage, and in this circumstance the skillful surgeon had good reason once again to congratulate himself upon the slowness with which he habitually proceeds in the operation of tracheotomy. In another case, I found the left carotid springing from the innominate trunk and crossing the tracheal artery. Moreover, it is not only not easier to puncture the trachea through the skin than at the bottom of a wound, but also the instrument may deviate from its proper course, and instead of penetrating into the air-tube, may pass into the œsophagus, as actually happened to my colleague, A. Bérard. Finally, if, at the very moment when you are about to introduce the canula, a false membrane lining the trachea should get in the way, how could you get at it through a narrow and deep wound? how could you see it in the midst of the flowing blood? Death would then be inevitable.

Some of you who have attended the clinic for several years, will remember a case presented in our wards two years ago. On the 27th of May a little girl four years old, attacked with croup, was brought to us; she was *in extremis*, and I hastened to perform tracheotomy. At the very moment when the trachea was exposed to view, I had cut a rather large thyroid vein, and in order to stop the somewhat abundant hæmorrhage occasioned thereby, I hastened to introduce the canula. Still respiration was not re-established; suffocation was very great, and the face of the little patient presented a frightfully livid, bluish hue. I withdrew the canula and introduced the dilator. The child was in a state of apparent death; respiration was suspended, and the pupils dilated; a sign which indicated that the asphyxia had reached a very high point. We then caused the thorax to perform the movements of breathing, and after a minute and a half or two minutes—the time seemed horribly long to us—we saw the patient make certain grimaces; a full inspiration recalled the air into the chest, and life returned. There had happened what I had already observed in the course of a long practice. A false membrane lined the larynx, the trachea, and the bronchii, and at the moment when I inserted the canula this torn false membrane had become engaged with my instrument, which it stopped up, and completely obstructed the passage of the air. When we had re-established the respiratory movement, after having withdrawn the canula and introduced the dilator, this false membrane appeared at the orifice of the trachea; we could seize it with our forceps and draw forth a long fragment of it, which was branched at its lower extremity. The canula was restored to its place and gave egress to other false membranes proceeding from the bronchial tubes, and the expulsion of which was caused by efforts of coughing, themselves excited by tickling the trachea with the end of a feather. The calibre of these tubular false membranes proved to us that the diphtheritic affection was deeply seated; and although respiration was re-established, we could not deceive ourselves as to the results of our operation. The child, in fact, died during the night.

The expeditious method exposes patients to an accident which

sometimes occurs, it is true, when the operation is performed according to the surest method. I refer to *emphysema* of the cellular tissue, resulting from the lack of parallelism between the incision of the soft parts and that of the trachea; and from the fact of the tracheal wound being too narrow, we would have difficulty in introducing the canula. This *emphysema* has nothing alarming about it. When it is limited to the neck and the immediate neighborhood of the wound, it will rapidly disappear, and is an accident of slight importance. But when it is more extensive and invades the chest, it helps to make respiration difficult; if it attacks the face, it has the additional disadvantage of disfiguring the patient and frightening the family. It may also attain extraordinary proportions and become almost general, an instance of which was observed by Dr. Millard; in such a case it becomes an accident of the most serious nature. Besides the dyspnoea which it brings with it, it gives, by reason of the swelling of all the tissues of the cervical region, such a depth to the wound that the ordinary canula becomes too short to reach even to the trachea, and it becomes necessary to resort to the most painful expedients.

Operate, therefore, slowly—very slowly. The trachea is open, but all is not yet over, and that which remains to be done is the portion of the operation, if not the most difficult, at least that which demands the greatest coolness and presence of mind. In fact, at this moment the blood becomes choked up in the bronchii, and as respiration is then more labored, the venous hæmorrhage, far from stopping, flows with even greater force. We must at once seize the dilator, which should be at hand, then introduce it closed between the lips of the tracheal wound, and when it is inserted open it moderately by withdrawing its rings. This manœuvre, easy as it seems, nevertheless demands some skill. It has very often happened that I have placed the end of my instrument between the muscles, and have introduced only one of its branches into the trachea. Here, too, it is necessary to proceed slowly; we must also go as deeply as possible. When the dilator is well placed the air penetrates readily, the blood, the mucosities, and the false membranes are expectorated, and respiration becomes ordinarily easy. At this period of the operation, the assistant who holds the head of the patient should bring it a little forward, in order to facilitate the introduction of the dilator, by relaxing the edges of the wound, and also in order to favor the exit of the blood and mucosities. If a somewhat abundant venous hæmorrhage takes place, as in the case which I just now mentioned, we must hasten to introduce the canula, and the hæmorrhage will at once cease.

The well-placed dilator will serve as a conductor for the canula, which has previously been provided with a ring of caoutchouc, or with gummed taffetas, designed to prevent the pavilion of the instrument from irritating and excoriating the skin of the neck. This introduction of the canula is often very difficult; sometimes the opening of the trachea is missed, and the instrument is plunged in front of this tube into the cellular tissue. We are notified that the canula is properly placed by the passage of the air and of mucus, and by the facility of respiration. It is indispensable that the canulas should be long,

and that they should be inserted into the trachea from one to two centimetres beyond the inferior angle of the wound in this tube. If the canula is too short, it becomes displaced by the efforts of coughing, gets in front of the trachea in a sort of *cul-de-sac*, which is always found there, and the patient dies by suffocation in a few minutes; a frightful accident, which I have three times had occasion to deplore, notwithstanding I had left with my patients students of medicine who had had some experience. In addition, the canula should be firmly fastened about the neck by means of cords.

When we have once penetrated into the trachea, the manner of getting there is in fact a matter of small moment; whether the operation has been performed more or less skillfully or more or less rapidly is equally immaterial, provided we have avoided hæmorrhage, for loss of blood has a very bad influence upon the sequelæ of the operation.

The subject of *treatment* remains to be considered. This wholly medical subject is so important that henceforward it will play the principal part, for while some almost invariably lose all their patients, others save a third part, and sometimes half of them. I should do wrong in speaking only of the treatment *to be followed*; we must also take into consideration that which has been pursued. Let us say at once, for it is the exact truth, that at the present day the greatest number of physicians are fortunately satisfied that the general medications of which I have spoken to you are often useless; that the chances of success will even be greater in the same proportion as these medications may have been less energetic; that blisters especially are attended by the serious disadvantages which I have pointed out to you; and the result is, that they no longer exhaust their little patients by sanguineous emissions, and that they are very careful not to apply blisters. I am, for my own part, thoroughly convinced that if we have been more successful in tracheotomy during a few years past, it is to be attributed as much to the happy direction of the treatment adopted by our associates, as to the method which I have recommended.

Before entering upon this subject of subsequent treatment, I must call your attention to a few details relative to the dressing of the wound, to which I may seem to attach an exaggerated importance; but the older I grow, the more convinced do I become that in therapeutics the minutiae occupy a much more important position than is commonly believed.

I have spoken to you of the bit of caoutchouc or waxed taffetas which should be placed between the pavilion of the canula and the skin, in order to prevent this latter and the wound from being irritated by the instrument and by the ribbons which keep it in its place.

The neck of the child should be enveloped in a *cravat* of knit wool, or in a large piece of muslin, in such manner that the child will expire into the tissue enveloping the neck, and inspire warm air impregnated with the vapor of warm water produced by the expiration. This is a capital precept; we thus avoid the drying of the cavity of the canula and that of the trachea; we avoid irritation of the mucous

membrane and the formation of coriaceous crusts analogous to those formed in the nasal fossæ of individuals attacked by coryza; crusts which, becoming detached in complete tubes, or fragments of tubes, cause frightful attacks of suffocation, and sometimes death, by the closing up of the canula. Before Dr. Paul Guersant and myself had adopted this method, we lost a great number of our patients by catarrhal pneumonia, but at the present time this accident is much more rare. It is probable that the introduction into the bronchii of warm and humid air is an infinitely favorable condition.

This method of surrounding the neck of the patient with a cravat had been pointed out by the ancients. The end they had in view, however, was to prevent the entry into the canula of dust, or of small bodies which might be floating in the air. As G. Martins has observed, it was a chimerical fear. Garengeot, however, had really seized the true indication when he recommended the placing of cotton in front of the canula, in order to *modify the air entering into the trachea*; or better still, to put over the orifice of this canula either a pledget of very light lint, or a piece of linen of rather coarse texture.* But independently of this precaution, useless as to the point of view from which they regard it, the ancients recommended that the air of the chamber in which the patient rested should be kept warm, for cold air might be injurious, that which reaches the lungs by the ordinary avenues of respiration being warmed in its passage through the mouth and the nasal cavities.† In our time it has been proposed, in order to comply with this indication, to use in the apartments the vapor of water, but we can readily understand that this method could not take the place of the more simple and more convenient method of the cravat.

There is also another thing to be done, without which cure is rare; I refer to the *cauterization of the wound*. Immediately after the operation, and also the first four succeeding days, all the surfaces of the incision must be vigorously cauterized once during the twenty-four hours with the stick caustic; thus we shall avoid an accident greatly to be feared—the diphtheritic affection of the wound, which becomes covered over with thick and fœtid false membranes. The specific inflammation, spreading in the surrounding cellular tissue, often devel-

* I shall be permitted to reproduce here textually the passage from Van Swieten, relative to this subject:

"Solliciti pariter fuerunt plerique hujus operationis descriptores, ut caverent "ne rina cum ære pulvisculi in illo volitantes patulum tubi orificium intrarent
"libere; hinc gossipo, linteo carpto, spongia, etc., tegi voluerunt extrorsum patens tubuli orificium. *Martinus* tamen usu didicit nullam notabilem inde
"noxam ægro accidere, licet non tegeretur tubuli orificium, quamvis etiam in
"domo non adeo nitida decumberet æger; si tamen inde quid metueretur, posset
"hoc faciliè evitari, si collo circumduceretur laxè rarum linteum, splenis ita in
"vicina tubuli dispositis, ut illud quidem tegeret tubi orificium, non tangeret."
—(Van Swieten, *loc. cit.*, p. 628.)

† "Expediet tamen ut ær parium calidior sit in loco quo decumbit æger, cum
"frigore suo nocere plus posset quàm dum communi respirationis via in pulmone
"nem trahitur, semper in transitu per os vel nares calescens utcumque."—(Van Swieten, *loc. cit.*)

ops in it a phlegmonous erysipelas of bad character, which becomes the seat of local gangrene, and at least of a violent symptomatic fever and general infection, from which recovery is rare. Dr. Millard says in his thesis that this cauterization is never performed by him at the very time of the operation; and according to information which I have gathered from one of the sisters attached to the hospital of the Rue de Sèvres, who has a thorough acquaintance with the treatment followed by my colleagues, the cauterization is never made, at the earliest, sooner than twenty-four hours after the operation; in addition, the child must be docile, and should have no fever, in which case they wait until the fever has subsided before cauterizing. I could not adopt this method of operating, because I have too often had occasion to know its disadvantages. When the fifth day has come, the surface of the wound is modified to such a degree that these accidents are no longer to be feared.

The operation being performed, the first thing of which the physician ought to think is the *alimentation*. Alimentation, and I have on several occasions, gentlemen, insisted upon this point, is the remedy *par excellence*, for the greater number of acute diseases, and especially for the diseases of infancy. Assuredly, abstinence, prescribed by Broussais, and still advised by a great number of physicians who cannot free themselves from the old man, and who retain too many of the prejudices of their early medical education—abstinence is one of the most mournful complications of diseases; the best suited to keep up the infection of the economy, and to open the door to the absorption of exterior miasms, and of the vicious excretions originating in the diseased body, and most opposed to that capacity of resistance which is the great promoter of convalescence and final cure. I do not mean that we must stuff our little patients with food; I mean only that we must satisfy their appetite, if they have any, and must force them to eat a little if they refuse their food altogether. I return to the point which I have already dwelt upon when speaking of the treatment of diphtheria in general: do not fear to employ intimidation. In that case, by assuming an apparent severity, whose expression I have exaggerated, I have many times compelled children to take nourishment, and I have prepared the way for a cure, which, without it, I had deemed impossible. Milk, eggs, cream, chocolate, soups, are the articles on which I have most insisted. If it is necessary, we must have recourse to the œsophageal sound, in order to introduce into the stomach the liquid food and nourishing drinks which the child refuses to take.

What I have just said sufficiently indicates that I prohibit, in the most formal manner, the continuation of the remedies, which, before the operation, may have been deemed more or less useful, namely: calomel, alum, purgatives, emetics, which cannot be compatible with the alimentation that I recommend.

It is a remarkable fact, that when tracheotomy is once performed, we no longer have to concern ourselves about the pharyngeal or laryngeal diphtheritic manifestations, which previously required to be so vigorously opposed; they get well of themselves. It seems that the

disease, when it has reached the air-passages, has exhausted all its force; and if, by affording a passage to the air into the respiratory apparatus, by means of tracheotomy, we prevent the patient from dying, cure will naturally result. I speak of the pharyngeal and laryngeal diphtheritic manifestation, for the cutaneous manifestations must be vigorously combated from the outset, by the topical remedies which I have pointed out, under penalty of seeing them become the occasion of an ominous resorption and a general infection, which must at any cost be avoided.

In the earlier operations of tracheotomy which I performed, I prescribed, after the example of M. Bretonneau, the sponging out of the trachea as far down as possible, with a small sponge fastened to the end of a piece of whalebone. Long since, I renounced this operation, as also the cauterization of the trachea, which I did either with the aid of a sponge filled with caustic, or by instilling this caustic in solution in the water. These manœuvres have seemed to me to be attended with more disadvantages than real advantages. I will say the same also of the *instillation of the chlorate of soda*, devised by Dr. Barthez, who, after having made them the subject of a communication to the Medical Society of the Hospitals, has himself discovered and acknowledged the uselessness of them.

An essential point is the frequent cleansing of the internal canula, so as to render the entry of the air as easy as possible. I recommend that it should be cleaned every two hours.

There now remains a final part of treatment, of considerable delicacy, and upon which I wish to dwell for a moment: it is that which concerns the withdrawal of the canula, and the final closure of the wound.

I do not speak of the method recommended by Dr. Millard, and which consists in at once withdrawing the canula after the first dressing of the wound, which my young and intelligent friend is accustomed to do at the end of the first twenty-four hours. Dr. Millard purposes, by acting thus, to aid the expulsion of the voluminous false membranes, which, being held back by the canula, might obstruct it, and excite attacks of suffocation. Doubtless, in the cases in which this suffocation would be produced, the indication is precise; but in ordinary circumstances I do not see the advantage, still less the necessity, of following this method. Nevertheless, I would assert it as a principle, that the sooner the canula is definitely withdrawn, the better it is; but it can rarely be withdrawn before the sixth day; and it should rarely be left beyond ten days. However, there are cases in which the larynx will remain completely closed during fifteen, twenty, forty-four days; an example of which I have seen in the case of a young girl, who, moreover, recovered. I call to mind, also, a child, who retained his canula for five years. This patient is still living, but he has a fistula of the air-passage.

At the end of the first week, the canula should be withdrawn, care being taken not to frighten the child, nor to make him cry. The poor little ones have become so accustomed to breathe through an artificial passage, that when we close this tube in order to facilitate the passage

of the air through the larynx, they are seized with fright, which is expressed by agitation, by cries, and consequently, by an acceleration of the respiratory movements. The larynx is still somewhat obstructed, either by slightly adherent false membranes, or by mucus, or by a slight tumefaction of the membrane; and besides, the laryngeal muscles have, perhaps, lost the habitude of contracting in harmony with the needs of respiration. There often results from this very great oppression; in the greatest number of cases, this oppression passes off well enough, if we can succeed in tranquillizing the little patient, and this is a part which belongs rather to the mother than to the physician. The wound should then be closed with fillets of English taffetas. If the sound of the cough and of the respiration, if the nature of the voice or of the cry indicate that the opening of the larynx is sufficiently large, we leave the dressing of the wound as it is; but if the air only passes in an insufficient quantity, we do not put on the fillets; we merely place on the wound a piece of linen covered with simple cerate, and wait until the next day to close it. If the air does not pass at all, we replace the canula, and two or three days later we recommence the attempt. As soon as respiration is well performed, in spite of the closing of the wound, we renew the dressing three or four times a day, and ordinarily the opening of the trachea is closed at the end of four or five days: there only remains the external wound, which we simply dress, and which soon heals in its turn.

There is a somewhat serious accident to which I have for a long time directed the attention of practitioners, and upon which Dr. Archambault has more especially insisted. I refer to the difficulty of swallowing. This difficulty consists in the passage of drinks through the glottis; there results from this a violent and convulsive cough each time the child attempts to drink, and the liquids which penetrate into the tracheal tube and the bronchii spurt in abundance through the opening of the canula. Besides the sufficiently serious disadvantages which may result from the contact of liquid food with the mucous membrane of the bronchii, food sometimes insoluble, and consequently irritating, there results from it especially an insurmountable disgust, and children rather suffer death from hunger than consent to take nourishment. Too often has this complication been the cause of death after tracheotomy, notwithstanding that I have used every effort to apply a remedy for it. The best method is to interdict all liquid food. I give to children very thick soup, vermicelli in milk or broth, to be eaten with a fork, and not with a spoon; hard eggs, eggs in milk, very much cooked, and meat slightly cooked and in rather large pieces; and I interdict every sort of drink. If thirst is too intense, I give pure cold water, and I take care to give it a long time after the meal, or immediately before it, in order to avoid vomiting. We must remark, however, that the accident of which I speak scarcely ever manifests itself earlier than three or four days after the operation, and that it rarely continues later than the tenth or twelfth day; however, I have seen it continue much longer in the case of certain little patients.

It would seem that the larynx, which opens so readily to receive

drinks and liquid food, would be sufficiently open to permit of the air necessary to supply the needs of respiration; it is, however, not so. We withdraw the canula, and we perceive that the opening of the larynx is still insufficient; and even when, a few days later, we have been able to close the wound with agglutinative fillets, the accidents continue with the same violence.

It is rather difficult to account for the cause of this accident. Dr. Archambault thinks that the child who has breathed through a canula for some days, loses the habit of giving harmonious movements to the muscles, which serve to close up the larynx, and to those which push the food into the œsophagus; and he says that he derived some benefit from the use of a rather ingenious method, which consists in closing the canula with the finger at the very moment when the patient is about to swallow something; thus the child is obliged to use his larynx, and the normal harmony is re-established. This little stratagem, in fact, succeeds very well in some cases, but in others it fails completely; and what I have said above demonstrates this, since, at the very time when the canula has been withdrawn and the wound is completely closed, the difficulty of deglutition continues, although the laryngeal respiration is perfectly free and regular; this depends, probably, upon the fact that the muscles of those parts have been affected by the paralysis of which I have spoken to you.

And now, gentlemen, I have set forth to you all I had to tell concerning tracheotomy and the various measures for performing it successfully. I have repeated to you what I have told you a hundred times during many years past. I would leave the subject, however, incomplete if I did not speak to you now of the conditions under which the operation ought to be performed.

And first, *At what period of croup is the duty of resorting to it most urgent?* In 1834, I wrote in the September number of the *Journal des Connaissances Médico-Chirurgicales*. I repeated in 1851, in an article entitled "*Nouvelles Recherches sur la Période extrême du Croup*," what you will find inserted in the journal *l'Union Médicale*, as follows: "So long as tracheotomy was in my hands an unreliable remedy, I said—we must perform the operation as late as possible; now that I can reckon up numerous successes, I say, it must be performed as early as possible." Taking from this proposition that which makes it appear too authoritative, and I still maintain it, when I say that *the sooner the operation is performed, the greater are the chances of success*. The ingenious experiments of Dr. Faure have, in fact, demonstrated that, by asphyxiating an animal slowly and methodically, there are produced during the last moments of life blood-clots in the heart and in the large vessels; we must, therefore, operate before death is imminent; but I hasten to add, that whatever may be the point to which suffocation has reached, even though the child might have but a few moments more to live, tracheotomy should be essayed; there is a chance of success *when the local lesion, when croup constitutes the principal danger of the disease*.

This restriction is important; for if the diphtheritic infection has profoundly affected the economy; if the skin and the nasal fossæ are

attacked by a special phlegmasia; if the frequency of the pulse, delirium and prostration, indicate a deep-seated poisoning of the system; if, in a word, you have to do with the malignant form of diphtheria, in which the peril consists, rather in this general condition of the system, than in the local lesion of the larynx or of the tracheal tube, *the operation must not be attempted*; death will invariably result.

The condition of success which leads all others, as Dr. Millard has well said in his excellent thesis, is the predominance of the characteristics of asphyxia among all the symptoms presented by the disease. "Unfortunately," as our confrère has also justly observed, "it is not always easy, in the midst of a combination of symptoms frequently very complex, to distinguish with certainty the disorders due to the mechanical affection, and those which are the expression either of the diphtheritic affection, or of a complication of another order." We are often obliged to resort to the urgent indication of causing a dying child to breathe, at the risk of discovering afterwards that he had no chance of recovery; and even when we suspect that he carries within himself the germs of death, we are still compelled, in the absence of an absolute certainty, to perform the operation almost without hope. "Operations of tracheotomy, performed under these circumstances," says, in conclusion, the author whom I take pleasure in quoting, "are attended by no other disadvantages than that of figuring among statistics in the same rank with others; they run the risk also of misleading opinion, and of bringing into discredit one of the most beautiful triumphs of the medical art. But the fear of diminishing the list of his successes should not by any means cause the physician too quickly to discard the operation; not until he has made a minute and thoroughly discriminating analysis of all the symptoms, and has detected a certain cause of death, has he the right to assume so serious a responsibility. This right we have exercised on several occasions, in cases about which there could be no dispute, without ever having had reason, on the autopsy, to regret having done so; but in every instance where we have harbored the least doubt, even though these conditions were very inauspicious, we have nevertheless taken the bistoury in hand, penetrated with the truth of the axiom, *Melius anceps quam nullum*." These, gentlemen, are wise and prudent words, and for my part, I accord to them my entire approval.

Finally, one subject more remains: it is that of *age*; a capital subject, demanding great consideration. I have told you, gentlemen, that among adults, tracheotomy, in cases of croup, did not succeed as well as with children; I have given this, perhaps unsatisfactory, explanation of it, namely, that in adults the anatomical disposition of the parts permitted a free passage of the air into the lungs for a much longer time, so that diphtheria had the opportunity to reach the bronchii and their most remote ramifications, before we would be compelled to have recourse to tracheotomy; but among children, this success is so much the more certain as the patient is the more advanced in years. This clearly appears, from the statistics prepared to elucidate this fact, from those among others published in the work of Dr. Millard. You know that before the age of two years croup is

rare; but as you might nevertheless meet instances of it, as I have myself met with it in children still at the breast, it is essential that you should know that at this period of life tracheotomy has but few chances of success. However, in 1834, I operated upon and cured an infant, thirteen months old, and I ask your permission to reproduce here the history of the case, as published in the number for June, 1834, of the *Journal des Connaissances Médico-Chirurgicales*.

On Sunday morning, May 11th, 1834, Dr. Corsin sent for me to see the child of a cartman, de la Petite-Villette, named Pierre Droulinger. It was a little boy, thirteen months old, still at the breast. He had been coughing for four days, but during Saturday night great oppression supervened; his cough, at first hoarse, ceased entirely, and he had lost his voice. Dr. Corsin was called, and finding the patient already in a desperate condition, he merely prescribed an emetic potion, and sent at once for me. The symptoms of croup were very evident, and the attacks of suffocation were so severe, and followed one another so closely, that I made preparations to perform the operation of tracheotomy.

The operation was laborious, and lasted more than ten minutes; finally, I opened the trachea, and at the very instant a large shred of false membrane spurted out some distance. I cleansed the trachea and the bronchii, instilled eight or ten drops of a solution of nitrate of silver, and inserted a canula. The poor child breathed easily; he looked at us in affright, and sought his mother, who had fled the house. We caused her to be called, and when she came the little one stretched out his hands to her with joy, at once began to undo her dress, and the handkerchief which covered her bosom, and seized the breast with avidity. For three days the canula was changed morning and evening, and every six hours we instilled nitrate of silver; on the fourth day it was injected for the last time. Every hour a few drops of water were thrown into the trachea, and the canula was sponged out. For ten days water was instilled. The child brought up pellicular concretions during four days, but on the second day, especially, he expectorated one which had considerable thickness.

The fever, which made its appearance a few hours after the operation, passed away on the third day. On the seventh day, the introduction of a new canula irritated the wound, caused the neck to swell, and excited anew a high fever. These accidents were quieted on the ninth day; on the tenth, the air passed in great measure through the larynx; on the eleventh, I withdrew the canula and closed the wound. The following day, air passed only through the larynx.

Very recently I had a second case of cure, somewhat similar to the former, although in the latter case the child, being two years old less six days, might be classed within the extreme limits of the age which I have pointed out to you. It was a little girl, born on the 30th of April, 1856; she was brought into our wards on the 24th of April, 1858, and presented all the signs of the last stage of croup. We found no trace whatever of pharyngeal diphtheria. I operated, and after the operation shreds of false membranes were discharged through the wound in the neck. Convalescence was long and difficult. Al-

though unsuccessfully attempted several times, the final withdrawal of the canula could not be accomplished until the seventeenth day. Diphtheria attacked the wound, and yielded only to repeated cauterizations. Finally varioloid supervened, but did not prevent her recovery. The child was taken from Hôtel Dieu on the 13th of May.

Science reckons a third case similar to these two: that mentioned by the *Gazette Médicale*, (1841 and 1842;) it was the case of a child twenty-three months old, who was operated upon and cured by Dr. Maislieurat-Lagémard.

That which among such young children lessens in a marked degree the chances of the success of tracheotomy is the lack of vital resistance, and the difficulty of nourishing the patients; there are also complications to be dreaded, such as the convulsions which are so easily occasioned at that age. Finally, the operation in itself is difficult, by reason of the smallness of the trachea and the shortness of the neck.

EDITORIAL AND MISCELLANEOUS.

— We have received the following Editorial from Dr. Douglas, and substitute it for our own closing remarks; cordially wishing, on retiring from the tripod, all our readers—spite of Rebellion, War, and Carnegie—a right merry Christmas and a happy New Year! R.

The present number closes the *Sixteenth Volume* of the MONTHLY. Six volumes had already appeared when the present senior editor united with Dr. PARKER, its first editor, in its management. At that time, the country was passing through a financial crisis, and it was a struggle with the MONTHLY, as well as with most medical journals. Ten volumes have, since then, been issued, the position and condition of the journal growing stronger with each succeeding volume. In 1858, Dr. STEINER united with the other editors, and the three have continued together up to the present time.

The war which now convulses our country has not, in its *blighting effects*, passed lightly by medical journals. One after another, they have been discontinued or suspended, so that now very few remain. Some of the best and longest established have succumbed, and the number grows less and less each month. How many will survive with the coming year cannot yet be said.

Although we have suffered greatly both by the necessary curtailment of our edition from the loss of subscribers in the disloyal States, and by the non-payment of a large number of subscribers in the loyal States, we propose to continue our labors, and look forward with hope to the commencement of a new year and the issuing of a new volume.

For several months past, other duties have prevented us from giving our personal attention to the journal. A regular and valued contributor kindly offered to superintend the issue during our absence. Unavoidable delays have occurred, incident to the circumstances, which will be avoided as much as possible in the future. Our absence has been prolonged much beyond the period proposed, and our present engagements still keep us away from our editorial duties. Arrangements have, however, been made which will insure an increased number of valuable contributions to the MONTHLY, and will afford its readers, through its pages, a more thorough *résumé* of medical literature than has heretofore been given.

DR. BENJAMIN LEE, whose communications are well known to the older subscribers, will, with the January number, assume the editorial management during the absence of the senior editor.

DR. ELSBERG, who kindly took our place for a few months when we were suddenly called away, will resume the control of the department interfered with by his editorial duties, and will hereafter contribute as formerly to our pages.

Reports on special subjects will form a feature of the forthcoming volume. One or more reports will appear in each number. DR. T. G. THOMAS will prepare a report on Obstetrics and Diseases of Women; DR. A. JACOBI, on Diseases of Children; and DR. F. J. BUMSTEAD, on Syphilis. We are also assured of valuable communications from many of the principal teachers and writers in the country. We expect to make the coming volume one of the best of the series yet published.

Our subscribers will observe that, in the midst of all our difficulties, we have endeavored to remain true to our motto: we have striven to progress, to increase the general fund of medical knowledge, and to advance in every way the true interests of the profession, so dear to our hearts. In making these efforts, we have counted upon the liberal support of our subscribers. We trust that it will not be found that we have counted in vain. We therefore call upon our patrons to renew their subscriptions early and promptly. We earnestly urge upon delinquents an immediate attention to their bills.

— "*Infidel Tendencies of Medical Men.*"—All physicians know how untrue are some of the popular notions on medical matters. How far, for instance, the idea that "Doctors are more proof against contagion than other people" is correct, our profession, alas! knows to its cost. But, though popular notions are sometimes utterly untrue, there is no doubt they generally do contain a certain amount of truth, viewed in the right light; and we have before us some remarks on

the popular belief (less prevalent, indeed, now than formerly) that "medical men are especially prone to Infidelity and Atheism," which we gladly transcribe.

In a recently published volume of "Miscellaneous Lectures and Reviews," by the Archbishop of Dublin, is a most able lecture on "The Influence of the Professions on Character." Speaking of the medical profession, he says, in reference to the popular belief last mentioned: In a question of fact, such as this, open to general observation, there is a strong presumption afforded by the prevalence of any opinion that it has, at least, some kind of foundation in truth. Certain peculiarities, he thinks, are to be found in the calling of a medical man, which, unless guarded against, are apt to exert an influence more or less subversive of his religious belief.

In the first place, a medical practitioner, as a rule, has no Sunday. The calls of his profession very often do not allow him to attend public worship, or, indeed, to observe his Sunday at all differently from other days. The evil of this is two-fold:—(1.) The advantage, whatever it may be, of public worship is lost. Now, rating this advantage at the very lowest, one is bound (observes the archbishop) to admit this much: that, independently of any edification derived from the peculiar religious services which men respectively attend, the mere circumstance of doing something every week *as* a religious observance must have some tendency to keep up in their minds a degree of respect, rational or irrational, for the religion in whose outward observances they take a part. (2.) When a man is habitually absent from public worship because he *cannot* attend, he is very apt to absent himself when he *can* attend; just as "a man placed in circumstances which interfere with his forming or keeping up domestic habits, or literary habits, or habits of bodily activity, is likely to be less domestic, less literary, more sedentary, than his circumstances require."

In the second place, his profession makes him familiar with death. The danger of such familiarity is this: that unless the instances of others' mortality lead him to live and act with a practical regard to his own, they merely serve to render him more and more insensible both to the sight and idea of death. The medical man, again, is constantly regarding death from one particular point of view, viz., "as the final *termination* of that state of existence with which alone he has *professionally* any concern." Now the habit of *thus* contemplating death must have a tendency to divert the mind from contemplating it in any *other* light; *e. g.*, not merely as the termination of this life, but as the beginning of another.

In the third place, he is apt to find a stumbling-block in certain

physiological and metaphysical theories (the immateriality of the soul, for instance,) which he receives—perhaps of his own accord, perhaps on the authority of some eminent divines—as part of revelation, or as essentially connected with it. Such theories “pass muster with the generality of readers and hearers, and, however unprofitable, may be to them at least harmless.” Not so with medical men. They know enough physiology to perceive the unsoundness of the arguments by which some of these theories are supported, and are apt to conclude that, since the theories are unsound, the religion of which they are assumed to form a part must be unsound also. They forget that such theories are by no means an essential part of revealed religion; that the Scriptures say nothing about them; and that, consequently, their irreconcilability with known physiological truths need not stagger their religious faith one iota. “It is much to be wished,” says the archbishop, “that religious persons would be careful to abstain, I do not say from entering on any physiological or metaphysical speculations, (which they have a perfect right to do,) but from mixing these up with Christianity, and making everything that they believe on matters at all connected with religion a part of their religious faith.”

Fourthly, it is rather a common belief with many people, and even with some professed divines, that the mode of a man's death, according as it is peaceful or troubled, is a sure criterion of the goodness or badness of his previous life. Now medical men know by experience that this is not the case. They find as a matter of fact that a dying person's state of mind is influenced just as often and just as much by the disease of which he is dying as by thoughts of past life and future prospects. Hence, when they see professed divines confidently stating things which are at variance with facts coming under their own experience, “they are in danger of drawing conclusions unfavorable to the truth of Christianity if they apply too hastily the maxim of *peritis credendum est in suâ arte*; if, in other words, they judge of the truth of their religion by the hypotheses of all who profess to teach it.”

The London *Medical Times and Gazette*, of November 30, in which we find the above remarks, editorially accompanies them further with the following:

“Such, very briefly, are the dangers to which the archbishop considers medical men, from the nature of their calling, to be peculiarly exposed. We are glad to find that a man, who, besides being himself a ‘divine,’ is confessedly a sagacious observer, and a cool, cautious, clear-headed reasoner, has not only thought the subject worthy of his consideration, but has also publicly stated the conclusions at which he has arrived. How far these conclusions are true, each one

of us can tell, in his own case, by appealing to his own experience. For our own part, we believe the dangers just pointed out to have a real existence; but we believe, at the same time, that the great majority of medical men are too much *alive* to their existence to fall into them. They *may* be, and, unless they resign their independence of thought, always *will* be, free thinkers on religious matters; but the mass of them are far too well informed to be or to become Infidels or Atheists.

"Before dismissing this subject, we may as well mention a few other notions which are commonly adopted as a part of popular religion, (or, to speak more correctly, of popular religionism,) but which are contrary to sound physiology. They tend, therefore, to discredit in the eye of the physiologist the religion to which they are appendages. Grief, indeed, is it to destroy the poetical dreams from which many pious minds receive consolation, yet they are but dreams.

"What, for instance, are the naked facts respecting the smiles of newly-born infants? Alas! the physiologist ascribes them to causes terrestrial, indeed; and knowing this, we confess that there is a sickening sense of disappointment which creeps over us when we read that exquisite poem in Keble's '*Lyra Innocentium*,' in which these smiles are ascribed to angelic promptings, or to the recollection of paradisaical bliss enjoyed by the spirit before it entered the human body at birth:

"But did the smile disclose a dream
Of bliss that had been his before?
Was it from heaven's deep sea a gleam,
Not faded quite on earth's dim shore?

"Or told some angel from above
Of glories to be his at last,
The sunset, crowning hours of love,
His labors done, his perils past?"

"The physiologist is tempted to doubt the inward soundness of a structure whose outward ornaments are so false, though beautiful, as these.

"We have mentioned the subject of 'death-bed scenes.' The physiologist who is tempted to read 'tracts' and popular religious literature will see with regret to how great an extent the describers of such scenes draw upon their imagination for their facts, and how thoroughly unreal and conventional are many of the descriptions. Consumption, for example, is painted in such uniformly rose color, as if it were such a gentle, easy death, and affording scope for the display of pious sentiments. Not one word of the terrible sufferings

from want of breath, the agonizing restlessness, and occasionally, it must be said, the pardonable querulousness and impatience. The Portuguese call it the 'death of the elect;' and a most learned and estimable clergyman, the Rev. J. M. Neale, in a small volume of 'Hymns for the Sick,' adopts the Portuguese idea.

"Religion is further discredited in the eyes of the physiologist by the readiness with which hysterical symptoms are regarded as proofs of Divine inspiration or miraculous interposition. The end of the matter is, that truth is to be sought at all price; and that the sober prosecution of physiology, though it may disgust us for a time with the false ornaments and appendages of religion, will, in the end, react upon the religious opinions of the masses, and purify them from any adventitious notions with which human frailty may have loaded them."

— We clip the following interesting item from the *Missouri Republican*, from a letter of one of its correspondents now in Cairo, Mo.:

"An association, called the Army Medical Society, has been formed here, composed of the surgeons and assistant surgeons connected with the various regiments and hospitals at Cairo, Bird's Point, and Mound City; its object being the improvement and diffusing of medical science among the members. The meeting was held at the office of Dr. Taggart, the medical purveyor at this post, and was temporarily organized by Surgeon Stahl being called to the Chair, and Brigade Surgeon Burke appointed Secretary. Brigade Surgeon Brinton explained the object of the meeting as being one in which all the surgeons now engaged in the army should feel a deep interest during the war. Surgeon Bringhurst moved that a committee be appointed to report a list of officers for the government of the Association. The following gentlemen were elected: Surgeon Stearns, President; Vice-Presidents, Surgeons Davis and Bowman; Secretary, Surgeon Taggart. They will hold a meeting once a week, and two papers will be read at each, for discussion; and every subject connected with army surgery will be discussed."

— The subjoined case, communicated to Dr. Green, of this city, by Dr. L. B. Bostford, Surgeon of the Marine Hospital of St. Johns, New Brunswick, is a valuable contribution to the history of foreign bodies in the larynx. It also abundantly illustrates the tolerance of this organ to instruments introduced for the removal of such bodies, or for the introduction of liquid medication.

ST. JOHNS, NEW BRUNSWICK, Oct. 11th, 1861.

Dear Sir—Knowing the interest you have in all matters affecting

the larynx, and thinking that the following case throws some light upon the controversy you have had with your opponents upon the entrance of instruments into the trachea, I forward you the particulars of it.

A sailor was admitted on the 6th inst. into the Marine Hospital, where I saw him about three hours after the accident occurred. He had been using a large-sized tailor's needle, threaded, and whilst holding it in his mouth and coughing, the needle entered the throat. Attempts were made to remove it before he came to the hospital, without success.

When I saw him the thread, a linen one, extended about three inches beyond the mouth; looking into the fauces, no needle could be seen. To ascertain the whereabouts of the needle, I took a gum catheter, cut off the end, passed a thread through, attached it to the thread connected with the needle, and passed the catheter in until it evidently followed the thread down to the eye of the needle. The catheter passed down about seven inches, and violent coughing was induced, such as follows the application of caustic solutions with the sponge.

The probang was next passed into the œsophagus, but produced no disturbance. Slight force applied to the thread caused the man to cough. I was assisted by Dr. Hamilton, of this city. Our diagnosis was, "needle in the trachea, point upward," and we concluded upon opening the trachea and extracting.

Upon further examination of the throat, and endeavoring to ascertain where pain might show the probable position, the man pointed to the neighborhood of the cricoid cartilage, and suddenly exclaimed, "I think I feel it." Pressing upon the space between the cartilages, I recognized what appeared to be the point of a foreign substance. Cutting down through the integuments into the crico-thyroid space, the point of the needle was made bare, and seizing it with a forceps, the needle was drawn out, the thread disappearing down the throat, as it followed the needle through the opening.

The peculiarities of the case were: 1st. The absence of cough, unless the thread was pulled. 2d. The power of speaking, without inducing spasm of the epiglottis.

There can be no doubt but that the needle was in the trachea, and it could not have penetrated through its posterior wall first from the œsophagus, because the probang caused not the slightest uneasiness, which it must have done by coming in contact with the needle, which was about two inches long.

If you think the above worth being recorded in a medical journal, it is at your service.

Believe me, dear sir, yours respectfully, L. B. BOSTFORD.

— Professor Peaslee recently performed the operation of tapping on a young lady at Pittston, Pa., and removed *one hundred and forty-nine pounds and three ounces* (149 lbs., 3 oz.) of dropsical fluid. It was weighed, in Dr. Peaslee's presence, by Dr. Lawson and Mr. J. Loveland, of that place. The abdominal circumference of the patient before the operation was *six feet and two inches*, (74 inches.)

This was the same patient, mentioned in the MONTHLY, June, 1861, from whom Dr. Peaslee removed *one hundred and thirty-five pounds* of fluid (135 lbs.) on the 29th of April last. The circumference then was five feet and seven inches, (67 inches.)

— *Preparation of a Work on "New Remedies."*—In connection with Prof. Percy, the undersigned is preparing a work on "New Remedies." It is based on the celebrated Essay of Dr. V. GUIBERT, to which the *Société des Sciences Médicales et Naturelles de Bruxelles* awarded its full prize, and the erudite elaboration thereof by Dr. RICHARD HAGEN, now in course of publication at Leipzig, Germany. Our work will embrace all valuable medicinal agents introduced into the Treatment of Disease since the year 1830, up to the present day, detailing their history, description, action and uses, and giving the most approved Formulæ of Preparation, Preservation, and Administration. In Formulæ it will be particularly full, for the use of both physicians and pharmacists. Novelty not being deemed a sufficient passport for admission into confidence unless sustained by merit, and with the only object—to be useful—and the only means—*Labor to approach the Truth*—constantly before us, we are determined that no really useful remedy, introduced during the last thirty years, shall be slighted, while no undue prominence shall be given to undeserving articles. Nor will uncertainty or ignorance at any point that the actual advance of science has not reached, be sought to be concealed by illusory hypotheses or ill-founded statements. Any heretofore unpublished information calculated to add to the practical utility of the work, that may be in the possession of any of our readers, will be gratefully received, carefully considered, and, if used, appropriately acknowledged. The lamentable circumstances that at present preoccupy the mind of every good citizen—our beloved country's trials—may somewhat delay the realization of our enterprise; but we bespeak for it, even in these troublous times, the co-operation of the profession.

— Will Exchanges please notice this Announcement?

ELSBERG.

